Centers for Medicare & Medicaid Services

FY 2004 GPRA Annual Performance Plan

FY 2003 Revised Final GPRA Annual Performance Plan

FY 2002 GPRA Annual Performance Report

January 2003

“WE ASSURE HEALTH CARE SECURITY FOR BENEFICIARIES.”

Mission Statement From
The Centers for Medicare & Medicaid Services

For questions or comments on the CMS Annual Performance Plan/Annual Performance Report, please contact:

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EXECUTIVE SUMMARY

AGENCY MISSION

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services. The creation of CMS in 1977 brought together, under one leadership, the two largest Federal health care programs--Medicare and Medicaid. These programs coordinate and finance health care for elderly, disabled, and low-income persons. When the programs were established in 1965, Medicare was created as a means of providing affordable health insurance to the elderly (and later to certain disabled persons). Medicaid was conceived as a Federal/State partnership in policy setting and funding and as part of the social safety net for low-income persons. The CMS has become the largest purchaser of health care in the United States, serving nearly 82 million Medicare and Medicaid beneficiaries.

The CMS's mission is to assure health care security for beneficiaries. The CMS's Strategic Plan – currently being updated – is developed in conjunction with the Strategic Plan of the Department of Health and Human Services (HHS) and outlines our goals for achieving this mission. The CMS's internal strategic planning process, the HHS Strategic Plan, the enactment of the Government Performance and Results Act (GPRA), and other HHS and government-wide programs have all emphasized the themes of accountability, stewardship and a renewed focus on the customer.

For CMS, this has resulted in a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. To ensure that CMS remains a responsive, dynamic and relevant government agency that serves its citizens, we are focusing our attention on citizen-centered governance in fiscal year (FY) 2004 and beyond. This Annual Performance Plan (APP) and Report (APR) emphasize this focus by identifying our significant processes and services, by helping us expand our resources in a way that enhances service to the public, by being accountable stewards of Agency resources, and by enabling us to monitor and evaluate our effectiveness. We will be communicating, collaborating, and cooperating with key customers, both public and private, to help us achieve the desired outcomes stated in this plan.

Our performance goals are linked to the HHS Strategic Plan goals and the newly revised CMS Strategic Plan.

Consistent with GPRA principles, CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. The Agency is confident that performance measurement under GPRA will substantially improve CMS's programmatic and administrative performance.

OVERVIEW OF PLAN AND PERFORMANCE REPORT

Accountability through Performance Measurement

Senior management has shown support for the CMS performance measurement process. They have assumed overall responsibility for GPRA performance goals and have appointed responsible, accountable goal leads and contacts.

Strong technical support for performance measurement also exists within CMS. We have established a Performance Measurement Technical Advisory Group made up of methodology and program experts across the Agency who examine the technical appropriateness, feasibility, and measurability of each of CMS's GPRA performance goals.

The chart below shows the number of performance goals and targets within those performance goals from the beginning of the GPRA process to the present submission, and it includes reporting tallies as appropriate.

PROGRAM PERFORMANCE REPORT SUMMARY

	Goals in Plan	Targets in Plan	Targets Reported	Targets Met	Unreported
1999	**18**	**22**	**22**	**20**	**0**
2000	**30**	**40**	**40**	**31**	**0**
2001	**33**	**54**	**52**	**40**	**2**
2002	**35**	**59**	**49**	**40**	**10**
2003	**36**	**58**	**N/A**	**N/A**	**N/A**
2004	**37**	**59**	**N/A**	**N/A**	**N/A**

Summary of FY 2002 Successes

Overall, CMS experienced positive results in FY 2002. Of the 35 goals being reported for FY 2002, we have 8 goals for which we do not have complete data. We have met or exceeded expectations for 20 of the 27 goals for which we have complete data.

Summary of FY 2002 Performance Challenges

Although we are not reporting success in meeting 7 goals in their entirety, we have made significant progress. For example:

- The FY 2002 target to increase the dollar amount of debt referred for cross servicing to 100 percent of eligible delinquent debt was not met. The CMS managed to refer approximately 92 percent of its eligible delinquent debt by the end of the fiscal year. The balance of the eligible debt will be referred in FY 2003.

- We did not meet our FY 2002 target to develop a model fraud rate program under the Comprehensive Error Rate Testing program because we did not receive the HCFAC funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.

- We did not reach our FY 2002 target of a 5 percent fee-for-service error rate; however, we continued our success of maintaining the error rate at 6.3 percent. We will further reduce the error rate by continuing to focus our corrective actions on areas of vulnerability identified by the OIG. We believe that by aggressively addressing specific high-risk areas we will continue to be successful in reducing the fee-for-service error rate.

- Although we met our target to implement the PECOS program, we did not meet our target of publishing the regulation pertaining to establishing and maintaining billing privileges. A revised provider enrollment form is dependent upon release of the regulation. These items are currently in the clearance process and we expect to issue them in FY 2003.

- We were unable to meet our goal to measure performance in processing enrollments/disenrollments in compliance with the Medicare+Choice beneficiary election provisions of the BBA. Due to the passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002), the implementation of the lock-in provisions has been statutorily delayed until FY 2005. Because there will be no data to report in FY 2003 and FY 2004, this goal has been discontinued.

- We did not meet our target to send appeals data collection instructions to the Medicare+Choice Organizations (M+COs). The CMS refocused its approach in response to industry concerns about imposing additional workload on the M+CO plans. Therefore, in an effort to relieve the burden on the M+COs, the appeals data collection will now be obtained through Independent Review Entities (IRE).

- Although we met our target to set accuracy standards to improve beneficiary telephone customer service, we did not meet out target to measure accessibility and caller satisfaction. These measures were discontinued due to a shift in focus to nationwide implementation of a single 800 number for beneficiary inquiries.

Pending FY 2000 and FY 2001 Performance Goals

Results are now available from the following previously unreported goals.

Goals Met

- FY 2001 goal to decrease the prevalence of restraints in nursing homes by 10 percent.
- FY 2001 goal to maintain a "clean opinion" on CMS's FY 2001 financial statement.
- FY 2001 goal to improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.
- FY 2001 target to increase lifetime pneumococcal vaccine rates.
- FY 2000 and FY 2001 goal to increase the number of women 65 and older who receive a mammogram (NHIS and Medicare claims data for 2000 and 2001, respectively).

Goals Not Met

- The FY 2000 goal to reduce the home health error rate.
- The FY 2000 goal to decrease the one-year mortality rate following hospital admission for heart attack.
- The FY 2001 goal to reduce the Medicare fee-for-service error rate to 6 percent.
- The FY 2001 goal to decrease the prevalence of pressure ulcers in nursing homes.
- The FY 2001 target to increase the annual influenza vaccination rate.

I. OVERVIEW OF PERFORMANCE MEASUREMENT

This Annual Performance Plan (APP) for CMS sets out specific performance goals for the Agency for FY 2004. It builds on previous APPs submitted to Congress and contains many enhancements. The CMS's APP complements and supports the Agency's FY 2004 budget, and is integral to it. In this Annual Performance Report (APR), CMS is reporting on Agency performance for its FY 2002 GPRA goals.

The Agency's APP is divided by budget category as a means of integrating budget and performance. The Table of Contents provides an easy-to-read road map indicating how the programs and performance goals are organized in the plan. The GPRA goals identified under each of our 11 budget categories are representative of the vital activities CMS performs to fulfill its mission. Thus, the APP does not reflect every activity and challenge encountered by the Agency. Using a representative approach is consistent with guidance from GAO based on the nature of the Agency's work.

Performance measurement results will provide a wealth of information about the success of CMS's programs and activities, and CMS uses performance information to identify opportunities for improvement and to shape its programs. The use of GPRA goals also provides a method of clear communication of CMS's programmatic objectives to our partners, such as national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges posed by our performance goals and are optimistic about our ability to meet them.

The President's Management Agenda of 2001 announced several reform initiatives with the primary objectives of making the Government more citizen-centered, results-oriented,

and market-based. In response to the President's five management objectives, CMS developed initiatives to vigorously move the Agency forward with a focus on five primary objectives: integrating budget and performance; enhancing strategic management of human capital; increasing competitive sourcing; improving financial performance; and expanding electronic government. Many of our performance goals are consistent with these objectives, as illustrated later in the Plan.

Consistent with the President's Management Agenda, CMS's initiatives include process reengineering efforts, improved methods of working and management initiatives that will enable the Agency to implement its long-term goals and objectives. For example:

- In order to expand e-government, we continue to improve our popular "medicare.gov" website to make the most of technology for the growing number of beneficiaries who have access to the Internet. It is a critical tool for our GPRA goals to improve the dissemination and understanding of Medicare information. Also, CMS makes use of computer based training (CBT) to educate our workforce on systems security issues and other subjects. This training enhances productivity by allowing employees the flexibility of scheduling training based on their individual schedule and makes a better use of time for both the employee and the Agency. It also provides a way for the employee to refer back to familiar training tools if necessary.

- Several CMS performance goals address the Agency's need to better manage its "human capital" in order to achieve its mission. As represented by our GPRA goal to improve our workforce planning, CMS seeks to identify existing workforce competencies and to eventually conduct gap analyses between current and future requirements and existing workforce skills and knowledge. Through our workforce planning efforts, we have identified broad competency areas that need to be targeted for skill and knowledge gap reduction, including strengthening management and leadership. To address this, CMS has developed a Leadership and Management Development Strategy (LMDS) to strengthen and increase the effectiveness of the Agency's leadership. This strategy is represented in our Plan by our goal to improve management structure. There is also a strong business case for our goal to strengthen and maintain diversity at all levels of CMS. By building a workforce that mirrors the diverse population we serve, we improve our effectiveness. These "human capital" goals will enable CMS and the Department of Health and Human Services (HHS) to effectively implement its Strategic Plan and long-term goals and objectives through a more effective workforce.

We have embarked on a national ad campaign, which assists beneficiaries and their caregivers to become active and informed participants in their health care decisions. In the fall of 2001, we implemented a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. These included expanded access to customer service representatives at 1-800-MEDICARE, expanded

web-based capabilities to help consumers compare health plan choices, and a national ad campaign on the new choices and new ways to get information on CMS programs. We conducted a similar national ad campaign in Fall 2002 to continue our promotion of 1-800-MEDICARE and www.medicare.gov. These strategies support a number of our GPRA goals in this Annual Performance Plan.

The use of performance measures to improve health care quality in the Medicaid program has been primarily undertaken by State Medicaid agencies. At the national level, we do not have information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. Therefore, CMS is beginning to work with States to jointly explore a strategy for State and Federal use of performance measures that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures.

Summary of Plan and Report

The CMS's total number of FY 2004 goals is 37. We carried over the majority of the goals in the FY 2003 plan, with new targets appropriate for FY 2004 focusing on meaningful outcomes. We have included a new budget category, which represents our Revitalization Plan. Our goal to Improve CMS's Information Systems Security has been relocated to this section. In addition, the CMS has honored its agreement made with the OMB during the Program Assessment Rating Tool (PART) process, and included two new program integrity goals measuring our contractor error rate and provider compliance rate. This year we will be reporting on the status of 35 FY 2002 performance goals.

An improvement in this year's plan is the indication in the reporting charts of linkage between our plan and the Department's Strategic Plan goals. In the reference section of the reporting charts, a numeral has been added to indicate to which goal(s) in the Department's Strategic Plan our FY 2004 GPRA **outcome** goals are linked. Goals associated with the President's Management Plan are identified by the  icon, which is also found in the reference section. Also in this section, as appropriate, we noted "See FY 03 Revised Final" for changes in FY 2003 goals.

The CMS's FY 2004 plan reflects our continued efforts to strengthen our coordination with other organizations and to enhance data verification and validation. With respect to data issues, CMS has been careful to cite and describe data sources for each individual goal, as well as particular data concerns or limitations. Data issues are explored further in the Appendix, Section A.4.

Each of our GPRA goals is outlined with targets for each fiscal year. Some goal targets are labeled "developmental" goals. We include these goals in our plan to show our commitment to certain priorities while acknowledging the challenges of developing a specific, measurable goal.

II. GOAL-BY-GOAL PERFORMANCE MEASUREMENT

In this section, we present our report on CMS's performance for FY 2002, and goals planned for FY 2003 and FY 2004. The report and goals are organized by budget category, including our new Revitalization Plan budget category. We begin by describing the category and presenting a table summarizing our FY 2002 performance and FY 2003 and FY 2004 goals. A performance summary for each budget category follows, which is then followed by goal narratives for the performance goals in that budget category.

Each performance goal is displayed within the associated major budget category. In general, if the actions planned to improve performance are mainly funded out of a given budget category, that is the category associated with the performance goal. The funding levels shown are the total dollars enacted or requested for each budget category, of which only a portion may be funding the specific activities or interventions described in a performance goal.

The 37 individual goal narratives for FY 2004 contain the following sections:

- *Baseline:* the initial data reported for the starting point of reference includes the year of the baseline data;

- *Target:* the desired performance level we plan to accomplish;

- *Discussion:* the rationale for selecting the particular performance measure, pertinent background information, and activities/interventions under way or planned to accomplish the goal;

- *Coordination:* the extent to which CMS coordinates with other organizations, such as other Federal agencies, State agencies, local agencies, private entities, and advocacy organizations;

- *Data source(s):* a description of the data used for measuring progress toward the goal; and

- *Verification and Validation:* the means for ensuring the accuracy and reliability of the data source(s).

Note:

- **We continue to reference some official CMS forms with the "HCFA" acronym, for example HCFA-1500. We are exercising fiscal restraint by exhausting our forms already on hand.**
- **The Medicare Peer Review Organizations (PROs) are now known as Quality Improvement Organizations (QIOs). All references have been changed accordingly.**

Medicare Benefits

Medicare Benefits	FY 2001 Actual*	FY 2002 Actual*	FY 2003 Current Estimate*	FY 2004 Estimate
Total Budget Authority	**$236.6 B**	**$252.2 B**	**$267.8 B**	**$278.6**

* Includes SMI transfer to Medicaid

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the Nation's largest health insurance program, which covers approximately 41 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For nearly four decades, this program has helped pay medical bills for millions of Americans, providing them with comprehensive health benefits they can count on.

Other representative goals related to this budget category but not listed in the chart are:

- Protect the Health of Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal (QIO2-04)
- Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram (QIO3-04)
- Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams (QIO4-04)
- Protect the Health of Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection (QIO5-04)
- Improve Beneficiary Telephone Customer Service (MO1-04)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-04)
- Improve Beneficiary Understanding of Basic Features of the Medicare Program (MO9-04)

Performance Goals	Targets	Actual Performance	Ref.
Improve satisfaction of Medicare beneficiaries with the health care services they receive			MB1 **3, 5**
--Managed care access to care	**FY 04:** 93% of beneficiaries **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop new baselines/ targets to include disenrollee data **FY 00:** Collect/share data to achieve 79% of plans by CY 2003* **FY 99:** Develop target	**FY 04:** **FY 03:** **FY 02:** Data collected (Goal met) **FY 01:** 90.5% of beneficiaries **(Baseline)** (Goal met) **FY 00:** Data collected (Goal met) **FY 99:** Target dev. (Goal met) **FY 98:** 74% of plans* **(Baseline)**	
--Managed care access to specialist	**FY 04:** 86% of beneficiaries **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop new baselines/ targets to include disenrollee data **FY 00:** Collect/share data to achieve 75% of plans by CY 2003* **FY 99:** Develop target	**FY 04:** **FY 03:** **FY 02:** Data collected (Goal met) **FY 01:** 83.7% of beneficiaries **(Baseline)** **FY 00:** Data collected (Goal met) **FY 99:** Target developed (Goal met) **FY 98:** 70% of plans **(Baseline)***	
--Fee-for-service access to care	**FY 04:** 95% of beneficiaries **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop baselines/ targets **FY 00:** Same as FY 1999 **FY 99:** Continue to develop measurement and reporting methodology	**FY 04:** **FY 03:** **FY 02:** Data collected (Goal met) **FY 01:** 92.8% of beneficiaries (**Baseline)** (Goal met) **FY 00:** Survey fielded in FY 2001 with baseline data available fall 2001 (Goal met) **FY 99:** Development continuing (Goal met)	
--Fee-for-service access to specialist	**FY 04:** 85% **FY 03:** Collect (& share) data **FY 02:** Collect (& share) data **FY 01:** Develop baselines/targets **FY 00:** Same as FY 1999 **FY 99:** Continue to develop measurement and reporting methodology	**FY 04:** **FY 03:** **FY 02:** Data collected (Goal met) **FY 01:** 82.8% **(Baseline)** (Goal met) **FY 00:** Survey fielded in FY 2001 with baseline data available fall 2001 (Goal met) **FY 99:** Development continuing with survey to be fielded in FY 2001 (Goal met)	

*later changed in FY 2001 Revised Final Annual Performance Plan

Performance Goals	Targets	Actual Performance	Ref.
Process beneficiary Medicare+Choice organization elections in compliance with the BBA beneficiary election provisions	**FY 03**: Goal discontinued (due to legislation) **FY 02**: Develop a target that measures performance in processing enrollments/ disenrollments in compliance with the beneficiary election provisions of the BBA	**FY 02**: (Goal not met due to legislation)	MB3 See FY 03 Revised Final
Timely ("same month") processing of clean Medicare+Choice enrollments equal to the effective date on the transaction ****Shading indicates the goal's targets prior to the current version.**	**FY 02:** See new measure (BBA election provisions, above) **FY 01**: 98% **FY 00:** 98% **FY 99:** 98%	**FY 02:** N/A **FY 01:** 99.3% (Goal met) **FY 00**: 98.7% (Goal met) **FY 99**: 95.6% (Goal not met) **FY 98**: System updated with managed care enrollments the month following receipt of the transaction (Baseline)	
Improve Medicare's administration of the beneficiary appeal process (Developmental)	**FY04:** **--**M+CO: Begin data collection --FFS: Developmental **FY 03:** **--**M+CO: Enhance data collection --FFS: Developmental **FY 02**: --M+CO: Issue OPL with reporting instructions --FFS: Evaluate data needs & capabilities **FY 01**: --Publish Operational Policy Letter (OPL) --Begin collecting baseline data **FY 00:** Have system in place for collection of managed care appeal data	**FY 04**: --M+CO: --FFS: **FY 03**: --M+CO: --FFS: **FY 02**: --M+CO: Reassessed data collection (Goal not met) --FFS: Evaluation complete (Goal met) **FY 01**: --OPL132 04/27/01 (Goal met) --Collection delayed (Goal not met) **FY 00**: Delayed due to burden to M+CO (Goal not met.) (Baseline developmental)	MB4 See FY 03 Revised Final **5**

Performance Results Discussion

Assuring health care security for our beneficiaries is our primary mission. While all of our GPRA goals support this mission in some way, we have attempted to identify several key measures to represent the Medicare benefits budget category. We want to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high-quality care, so it is important that we select goals that address a range of issues--administrative and care-related.

Beneficiary Satisfaction - Our multi-year efforts to improve beneficiary satisfaction with the health care received apply to both managed care and fee-for-service (FFS). In an effort to capture more complete information for the managed care portion, data from a managed care disenrollee survey is combined with survey data from current managed care enrollees. Baselines and targets have been recalculated to reflect this change. In order for the increases to be statistically significant, these are long-term targets with reporting due at the end of the 5-year period.

Our efforts to improve beneficiary satisfaction are ongoing by continuing to collect and share CAHPS information from beneficiaries. Specific presentations on the CAHPS surveys, from which these measures are developed, have been made to individual Medicare managed care plans, to Quality Improvement Organizations (QIOs) at meetings of the American Health Quality Association, and to beneficiaries on the Medicare Health Plan Compare website. In addition, we have established a website to provide further assistance to QIOs on issues related to FFS. We are currently developing a website for Medicare managed care issues to be available to QIOs and other researchers.

Timely Enrollment - While encouraging our beneficiaries to choose the health plan best suited for their needs, we want to ensure timely enrollment into managed care with no interruption in health care delivery or payment. Unfortunately, we fell short of our FY 1999 target. The managed care organizations (MCOs) were unfamiliar with the new enrollment timeframes. Also the data extraction technique included some inappropriate transactions in the counts, resulting in the percentages being lower than they actually should have been. The MCOs have since gained experience with the new enrollment timeframes, and the extraction technique has been improved to provide more accurate data. Thus, in FY 2000 and FY 2001, we met and exceeded our target of 98 percent. For FY 2002 our goal was to develop targets that measure performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA regarding lock-in provisions and plan benefit packages. However, due to the passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002), the implementation of the lock-in provisions has been statutorily delayed until FY 2005. Because there will be no data to report in FY 2003 and FY 2004, this goal has been discontinued.

Beneficiary Appeals - It is important that we address beneficiary appeals for both managed care and FFS programs in Medicare. For example, appeals in the managed care program usually relate to “access to care” while the appeals issue in the FFS program is usually nonpayment for service. In FY 2002 the M+CO appeals target was to send data collection instructions to the M+COs. However, in response to industry concerns about imposing additional workload on the M+CO plans, CMS decided to refocus its approach, thus it did not meet this target. The data collection will now be obtained through Independent Review Entities (IRE) alleviating any burdens to the M+COs. The FFS FY 2002 target was met by having the appeals data re-evaluated to determine future needs for improving the administration of this essential beneficiary protection. The CMS

is now considering whether its data needs would best be served by a unified system that can incorporate and utilize both FFS and M+CO data.

Performance Goal MB1-04

Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive

Baselines (New for FY 2002-2004 Goals 1[)]: CY 2000 Managed care - (a) Getting needed care for illness or injury: 90.5 percent of beneficiaries enrolled in a Medicare managed care (MMC) plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: 83.7 percent of beneficiaries enrolled in a managed care plan reported that it was not a problem to see a specialist that they needed to see. CY 2000 Fee-for-service (FFS) - (a) Getting needed care for illness or injury: 92.8 percent of beneficiaries enrolled in the original Medicare FFS (MFFS) health plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: 82.8 percent of beneficiaries enrolled in the original Medicare FFS health plan reported that it was not a problem to see a specialist that they needed to see.
FY 2004 Targets: Same as FY 2002/2003.
FY 2003 Targets: Same as FY 2002.
FY 2002 Targets: Managed Care - Direct efforts to achieve by the end of CY 2004 for (a) Getting needed care for illness or injury: 93 percent of beneficiaries, and (b) Access to a specialist: 86 percent of beneficiaries. These efforts include: (1) continue to collect MMC-CAHPS and Disenrollee data and make available to Medicare managed care plans, Medicare Quality Improvement Organizations (QIOs) (formerly known as PROs) and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice. FFS - Direct efforts to achieve by the end of CY 2004 for (a) Getting needed care for illness or injury: 95 percent of beneficiaries, and (b) Access to a specialist: 85 percent of beneficiaries enrolled in the Original Medicare FFS health plan will report that it was not a problem to see a specialist that they needed to see. These efforts include: (1) continue to collect MFFS-CAHPS data and make available to Medicare QIOs and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice. **Performance:** Goal met. We continue to collect CAHPS data and assist in quality improvement initiatives by sharing data with plans, QIOs and beneficiaries toward meeting our ultimate target by the end of CY 2004.
FY 2001 Targets: Developmental. Managed care - Develop new baselines/future targets including data from disenrollee survey. FFS - Develop baselines/future targets based on survey results. **Performance:** Managed care - Goal met. New baseline and 5-year target measures (see above) were developed using data collected from both the MMC and Disenrollee CAHPS for 2000, regarding beneficiary access to care and specialists. FFS – Goal met. Baselines and 5-year target measures (see above) were developed from 2000 data collected in Round 1 MFFS-CAHPS for 2000, regarding beneficiary access to care and to specialists.

1 Managed Care - Data for beneficiaries who voluntarily disenrolled from their managed care plans became available in FY 2001 from the 2000 survey and were combined with Consumer Assessment of Health Plans Survey (CAHPS) data for current enrollees to get a more complete picture of plan performance.

FFS - Baselines established with Round 1 Medicare FFS (MFFS) CAHPS data from CY 2000.

(Continued from previous page) **Baselines for FY 2000 Goal** Managed care without disenrollees - (a) Getting needed care for illness or injury: In 1998, in 74 percent of plans, at least 90 percent of beneficiaries reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Ease of getting referral to a specialist: In 1998, in 70 percent of plans, at least 80 percent of beneficiaries reported that it was not a problem to get a referral to a specialist that they needed to see. Fee-for-service (FFS) - Developmental. Baseline data will become available in FY 2001. The CAHPS FFS survey was fielded in Fall 2000.)
FY 2000 Targets: Managed care - Continue efforts to achieve by CY 2003, (a) in 79 percent of plans, at least 90 percent of beneficiaries report that they could usually or always get care for illness or injury as soon as they wanted, and (b) in 75 percent of plans, at least 80 percent of beneficiaries report that it was not a problem to get a referral to a specialist that they needed to see. FFS - Targets will be established after baseline data become available in FY 2001. **Performance:** Managed care - Our interventions to improve beneficiary satisfaction have continued with regard to encouraging health plans and the PROs to use CAHPS measures in their quality improvement efforts. In an effort to capture more complete data for this goal, input from disenrolled beneficiaries will be included in the CAHPS survey. Therefore, baselines and future targets will be recomputed. FFS - We began collecting CAHPS FFS data in Fall 2000.
FY 1999 Targets: Managed care - Develop target. FFS - Continue to develop measurement and reporting methodology. **Performance:** Managed care - Goal met. Baseline and target developed. FFS - Goal met. Development continuing with survey to be fielded in FY 2001.

Discussion: A fundamental goal is that beneficiaries are our primary customers and one of CMS's main reasons for being is to assure satisfaction in the experiences beneficiaries have in accessing care for illnesses and injuries when needed, including their access to care of specialists. In response to the need to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Health Plans Surveys (CAHPS). The CMS fields these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care plan as well as those enrolled in the original Medicare fee-for-service plan and provides comparable sets of specific performance measures collected in CAHPS to Quality Improvement Organizations (QIOs), health plans, and beneficiaries through various means, including the National *Medicare & You* Education Program (NMEP).

Provision of CAHPS performance information assists beneficiaries in their health plan choices under Medicare. Annual development of specific performance measures also permits use of CAHPS as a tool for monitoring beneficiary experiences in and satisfaction with differing care delivery modes and in different regions of the country. Plan-specific measures provide direct incentives for managed care plans to improve performance and health services quality. FFS measures, reported by geographic area, assist in development of strategies to improve care quality through targeted interventions implemented either directly by CMS or through State Medicare QIOs and other partners.

The performance indicators and satisfaction measures disseminated through the NMEP also are part of a long-term strategy to monitor and evaluate the use of specific services provided through Medicare, and improve consumer satisfaction regarding the services received. The CMS conducts research on the use and understanding of these measures by beneficiaries as well as in the effectiveness of specific initiatives monitored by these measures in improving service quality. Our baselines for both managed care and FFS satisfaction are already fairly high. Given this type of survey for a large group of people and considering the unrelated factors that could influence responses, we know that a target of 100 percent satisfaction is unrealistic. Nonetheless, our targets are challenging and are set for a 5-year period in order for the percentage increases to be large enough to be statistically detected.

Coordination: The development and implementation of Medicare consumer assessment measures are coordinated by CMS's central and regional offices. Dissemination of information sets based on these measures is also coordinated through an array of Federal, State, and local agencies, and advocacy groups, including the Social Security Administration, the Administration on Aging, American Association of Retired Persons, National Association of Area Agencies on Aging, National Caucus and Center on Black Aged, National Asian Pacific Center on Aging, and other groups. The CMS also coordinates specific quality improvement activities and information dissemination through the QIOs and other partners.

Data Source(s): The Medicare CAHPS are a set of annual surveys of beneficiaries enrolled in all Medicare managed care plans and in the original Medicare fee-for-service plan. The CAHPS for managed care was fielded with a sample of 600 beneficiaries in each of over 250 managed care plans in Fall 2000, i.e. FY 2001. Data collection for managed care disenrollees (beneficiaries who voluntarily left their plans) began in Fall 2000 within the same managed care plans. This survey obtains information about the experience of beneficiaries in their former health plan. Data from this survey are combined with the information collected from current enrollees to obtain a more complete picture of plan performance.

Data collection in CAHPS-FFS began in Fall 2000 (FY 2001) with samples of 600 beneficiaries in 275 geographic areas nationally. Information comparable to that obtained from the MMC-CAHPS were available from the MFFS-CAHPS in FY 2001 and are available to beneficiaries and others on the Medicare Health Plan Compare web site. The Medicare managed care and the Medicare FFS CAHPS surveys consist of between 90-95 questions and have undergone extensive cognitive testing with Medicare beneficiaries. The information collected in the Medicare CAHPS is comparable to other CAHPS information collected in surveys of persons enrolled in commercial, i.e. non-Medicare health plans.

Verification and Validation: The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 2.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare

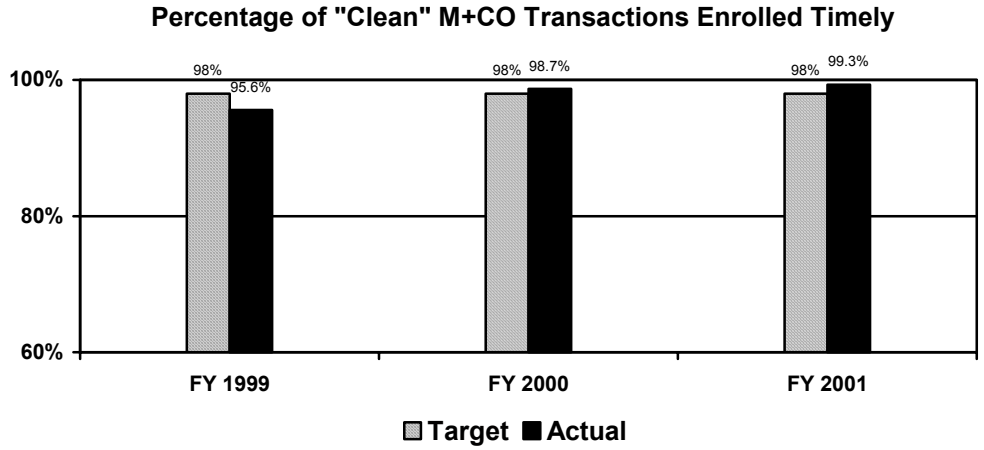
beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response. More detailed plan-level and geographic-area CAHPS results are also checked for consistency with the experience and satisfaction data collected both on a national and regional basis annually in the Medicare Current Beneficiary Survey (MCBS). Although MCBS satisfaction questions do not match those in CAHPS on an item-by-item basis, several measures are similar enough to be used for consistency checking especially with regards to national trending of beneficiary experience.

Performance Goal MB3-02

Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions (*Discontinued after FY 2002*)

Baseline: Prior to CY 2002, there was no ability to track elections at the plan benefit package (PBP) level or to apply the lock-in provisions affecting enrollments/disenrollments.
FY 2002 Target: Developmental. Develop a target that measures performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA. **Performance:** Goal not met and discontinued due to legislation.

Baseline: In FY 1998, for clean* managed care plan enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system updates beneficiary records with requested enrollment effective dates by the first of the following month.
FY 1999-2001: For 98 percent of clean* Medicare+Choice organization (M+CO) enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system will update beneficiary records with enrollment effective dates equal to the effective dates on the transactions. (See chart below) *clean = information submitted by M+CO is correct



Discussion: For FY 1999 through FY 2001, this performance goal measured the timeliness of CMS systems' processing of Medicare beneficiary enrollment transactions received from Medicare+Choice organizations (M+COs) as specified by the Balanced Budget Act of 1997 (BBA).

The performance goal for FY 2002 measured the processing of enrollment and disenrollment transactions received from M+COs in compliance with the beneficiary election provisions of the BBA effective in 2002. M+COs contracted with CMS to provide medical services to Medicare beneficiaries. In providing such services, M+COs

could offer multiple plan benefit packages (PBPs) for members to elect. The BBA requires that beneficiary elections be tracked at the PBP level and also specifies time periods when beneficiaries may elect to enroll or disenroll from M+COs or to change PBPs. The CMS is maintaining PBP information for all members of M+COs for the first time in 2002.

The BBA requires that if a beneficiary wishes to make an election during an open enrollment period (OEP), he/she must do so in the first 6 months of CY 2002 or the first 6 months of Medicare eligibility (for new Medicare beneficiaries). In addition, only one election may be made during this timeframe. This election period is reduced in calendar year 2003 to 3 months. Elections are defined as enrollments and disenrollments into and out of a M+CO as well as PBP changes within an M+CO. These requirements are known as the lock-in provisions. There are some exceptions to these provisions related to special election periods (e.g., the beneficiary moves out of the M+CO's service area; the M+CO terminates).

To support these requirements, M+COs were to submit new data. In addition, since the lock-in provisions severely limited when such data could be submitted, it could only be accepted during certain times of the year. Currently, M+COs can submit enrollment/ disenrollment data at any time. The CMS receives and edits M+CO transaction data for validity. The system ensures that each enrollee is a Medicare beneficiary and entitled to make an election.

The passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002) has statutorily delayed the implementation of lock-in provisions until FY 2005. As a result of this Act, beneficiaries are allowed to continue to enroll and disenroll on a monthly basis. However, CMS will require the reporting of the PBP Identifier and the Application Signature Date on enrollments, and on the new PBP election transaction code 71 to process PBP elections. M+COs will not report the type of election (i.e. Annual Election Period, Open Enrollment Period). Also, CMS will not implement the lock-in provisions, so election limits will not be counted or applied to any transaction. Given the impact of the Act on this activity, this goal is discontinued at this time.

Coordination: The CMS will coordinate its efforts with M+COs and beneficiaries. The improvements stated above are directly related to accurate submittals by M+COs. The CMS will reject noncompliant transactions and notify M+COs of errors. Beneficiaries will be informed about the election provisions so they are aware of the revised timeframes. In addition, as changes are made to the current system and/or as the new system modules become active, user-impacted changes will be communicated to the M+COs and training provided as necessary.

Data Source(s): The source of the data will be the Group Health Plan (GHP) system, which maintains enrollment and disenrollment information.

Verification and Validation: The GHP system will be equipped with edits to verify PBP data and the election timeframes. A percentage will be developed based on preliminary data received during the last quarter of FY 2002.

Performance Goal MB4-04

Improve Medicare's Administration of the Beneficiary Appeals Process

Baseline: Developmental. Baseline data collection for Medicare + Choice Organizations (M+CO) appeals will begin in FY 2002 and continue through FY 2003.
FY2004 Target: Developmental. **M+CO:** Begin collection of Independent Review Entity (IRE) data. **FFS**: Developmental
FY 2003 Target: Developmental. **M+CO:** Enhance data collection at the Independent Review Entity (IRE) level. **FFS:** Developmental
FY 2002 Target: Developmental. **M+CO:** Issue OPL with reporting instructions. **Performance:** Goal Not Met **FFS:** Evaluate CMS's FFS appeal data needs and capabilities. **Performance:** Goal Met
FY 2001 Target: Publish Operational Policy Letter (OPL) and begin collecting baseline data for M+COs. **Performance:** OPL published 04/27/2001, collection delayed.
FY 2000 Target: Implement system for collection of M+CO appeal data. **Performance:** Goal not met due to added burden to M+CO.

Discussion: The appeals process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. Under fee-for-service (FFS) Medicare, beneficiaries have the right to appeal a denial of payment by a Medicare fiscal intermediary (FI) or carrier. This appeal comes after the service has been provided. The appeals process takes on added significance under the M+CO programs because these appeals may also involve pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

M+CO Data Collection:
Starting in FY 1999, CMS required M+COs to collect aggregate level appeals data in order to report to beneficiaries upon request. The CMS captures data on appeals activities not resolved at the M+CO level and that have proceeded to a higher level of review by an independent CMS contractor. The CMS does not yet capture data on plans' internal appeals activity, due to concerns regarding burdening plans with increased reporting requirements.

Various methods of data collection have been discussed and abandoned in light of industry concerns that these methods would be too burdensome. In FY 2002, CMS determined that the need to collect data at the M+CO level required reassessment. In response to industry concerns, CMS decided to enhance the data collection at the Independent Review Entity (IRE) level. In late FY 2002, CMS met with the IRE to discuss further enhancements that can be made to the M+CO data it already receives.

The CMS met with representatives of the IRE to review enhanced data elements and finalize a report on CMS's data needs. The IRE would report to CMS via a new system

that would incorporate both the FFS and M+CO systems. The IRE is also working with CMS to determine whether additional data elements are needed to assist them in their monitoring of M+CO.

FFS Data Collection: In FY 2001, CMS awarded a contract to analyze FFS data from FIs and carriers. These evaluative efforts have been undertaken to determine FFS future data needs. The contractor's initial findings were submitted to CMS in FY 2002. Late in FY 2002, the contractor submitted a draft business case analysis, which outlined both user and system requirements. The CMS staff reviewed the requirements and made comments, that were incorporated into a refined document. This document was used to provide guidance on future requirements. The CMS is now weighing the benefits of a system that can utilize both FFS and MCO data.

Combined M+CO/FFS Data Collection
In FY 2002, CMS reassessed its data needs and system/business requirements for both FFS and M+CO. The same contractor that analyzed the requirements for individual M+CO and FFS systems is also performing a Business Case Analysis (BCA) of the benefits of a combined system. The contractor has met with representatives of both the FFS and M+CO teams to discuss modifications to the BCA.

Coordination: The CMS has worked closely with the Center for Health Dispute Resolution (CHDR), health insurance industry representatives from the American Association of Health Plans, Blue Cross Blue Shield Association, the Health Insurance Association of America, and representatives from specific managed care plans. The CMS has also sought input from the beneficiary advocacy community (e.g. the American Association of Retired Persons, Consumer Coalition for Quality Health Care, National Senior Citizens Law Center).

Data Source(s): Aggregate M+CO appeals data will be reported by the M+CO to the IRE. The IRE will maintain data in its system and provide reports to CMS. The IRE ultimately will report data into the Medicare Appeals System (MAS). Aggregate FFS data are entered into the Contractor Reporting of Operational Workload Data (CROWD) system by FIs and carriers.

Verification and Validation: The CMS utilizes an Independent Validation and Verification (IV&V) contractor to evaluate the performance of the contractor providing deliverables.

Quality of Care:
Quality Improvement Organizations

Quality Improvement Organizations	FY 2001 Actual	FY 2002 Actual	FY 2003 Current Estimate	FY 2004 Estimate
Total Budget Authority	**$110.9 M**	**$382.8 M**	**$716.1 M**	**$99.6 M**

Under the Quality Improvement Organization (QIO) program, formerly known as the Peer Review Organization (PRO) program, CMS contracts with 53 independent physician organizations (one in each State, D.C., Puerto Rico, and the Virgin Islands) to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. The QIO responsibilities are specifically defined in the portion of the contract called the Scope of Work (SOW). Each SOW is three years in duration and each SOW can vary the activities the QIOs perform. Funding patterns tend to vary substantially from year to year. The QIO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

Quality improvement in nursing homes is a major focus of the QIOs under the 7th SOW. In fact, there was a nation-wide rollout of QIO nursing home activities in November 2002. There is also an increased emphasis for the QIOs to work with the stakeholders, including the State Survey & Certification agencies to improve care in the Nursing Home Quality Initiative. This initiative, which is an important step in CMS's comprehensive quality strategy, is a multi-prong effort that consists of (1) CMS's continuing regulatory and enforcement initiatives conducted by State survey agencies; (2) new and better consumer information on the quality of care in nursing homes; (3) community-based quality improvement programs offered by Quality Improvement Organizations; and (4) collaboration and partnership to leverage knowledge and resources. The QIOs will work with nursing home providers to improve performance on agreed upon measures and to implement quality improvement projects. See Survey & Certification Quality of Care budget section of our Plan for more information about the Nursing Home Quality Initiative.

The following goals from the Survey & Certification Quality of Care budget section of our Plan are related to this budget category but are not listed in the report below:

- Decrease the Prevalence of Restraints in Nursing Homes (QSC1-04)
- Decrease the Prevalence of Pressure Ulcers in Nursing Homes (QSC2-04)

Performance Goal	Targets	Actual Performance	Ref.
Improve heart attack survival rates -- Lower the 1-year mortality rate for Medicare beneficiaries following hospital admissions for heart attack	**FY 03:** Goal discontinued **FY 02**: 27.4% **FY 01**: 27.4% **FY 00**: 27.4 %	**01-02:** Expect data 6/04 **00-01:** Expect data 6/03 **99-00:** 33.2% ◆ (Goal not met) **(NEW DATA)** **98-99**: 32.3%◆ **97-98:** 31.8%◆ **96-97:** 31.1%◆ **95-96:** 31.2%*◆ **(Baseline)** (* revised from 31.4%) ◆data not risk adjusted	QIO1 See FY 03 Revised Final
Increase annual influenza (flu) and lifetime pneumococcal vaccinations (MCBS) -- Flu	**FY 04:** 72.5% **FY 03:** 72.5% **FY 02:** 72 % **FY 01:** 72 % **FY 00:** N/A	**FY 04:** Expect data 12/05 **FY 03:** Expect data 12/04 **FY 02:** Expect data 12/03 **FY 01:** 67.4% (Goal not met) **(NEW DATA)** **FY 00:** 70.4% **FY 99:** 69.3% * **FY 98:** 68.5 %* **FY 97:** 67.1 %* **FY 96**: 65 % **FY 95:** 61 % **FY 94:** 59% (MCBS) **(Baseline)**	QIO2 **1, 3** See FY 03 Revised Final
-- Pneumococcal	**FY 04:** 69% **FY 03:** 67%♦ **FY 02:** 66% **FY 01:** 63% **FY 00:** N/A ♦ Revised Target	**FY 04:** Expect data 12/05 **FY 03:** Expect data 12/04 **FY 02:** Expect data 12/03 **FY 01:** 63.3% (Goal met) **(NEW DATA)** **FY 00:** 62.7% **FY 99:** 61.7 %* **FY 98:** 56.1 %* **FY 97:** 50.9 %* **FY 96:** 44.1 % **FY 95:** 34.6 % **FY 94**: 24.6 % (MCBS) **(Baseline)** * includes community dwelling beneficiaries only	
Increase rate of annual influenza (flu) vaccination (NHIS) **** Shaded area indicates goal based on previous data source.**	**FY 01:** Switched to new data source. (see above) **FY 00:** 60% **FY 99:** 59%	**FY 00:** 64% (Goal met) **FY 99:** 66% (Goal met) **FY 98:** 64% **FY 97:** 63% **FY 95:** 58% **FY 94:** 55% (NHIS) **(Baseline)**	

Performance Goal	Targets	Actual Performance	Ref.
Increase biennial mammography rates (National Claims History file)	**FY 04:** 52%♦ **FY 03:** 51.5%♦ ♦**Measure based on 2002 HEDIS®**	**03-04:** Expect data 8/05 **02-03:** Expect data 8/04 **01-02:** Expect data 8/03 **00-01:** 51% **(Baseline)**	QIO3 **1, 3**
	FY 03: See Above **FY 02:** 52%* **FY 01:** 51%* ***Measure based on 1999 HEDIS®**	**01-02:** Expect data 8/03 **00-01:** 51.6 % (Goal met) **(NEW DATA)** **99-00:** 50.5% **98-99:** 49% **97-98:** 45% **(Baseline)**	See FY 03 Revised Final
Increase biennial mammography rates (NHIS) **** Shaded area indicates goal based on previous data source.**	**FY 01:** Switched to new data source (see above) **FY 00:** 60% **FY 99:** 59%	**FY 01:** N/A **FY 00:** 68.1% (Goal met) **(NEW DATA)** **FY 99**: 66.8% (Goal met) **FY 98**: 63.8% **FY 94:** 55% (NHIS) **(Baseline)**	
Improve the rate of biennial diabetic eye exams	**FY 04:** 69.2% **FY 03:** 68.9% **FY 02:** 68.6 % **FY 01:** 68.3 % **(69.0% recalculated)**	**02-04:** **01-03:** Expect data Spring '04 **00-02:** Expect data Spring '03 **99-01:** 68.9% (Goal met) **(NEW DATA)** **98-00:** 68.1% **97-99:** 67.8% **(Baseline)** (*revised from 68.5%)	QIO4 **1, 5**
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection	**FY 04:** 54.8% **FY 03:** 49.8%	**FY 04:** **FY 03:** **FY 02:** **FY 01:** 47.4% **(Baseline)**	QIO5 **1, 5** See FY 03 Revised Final

Performance Results Discussion

Improving the quality of care for Medicare beneficiaries is one of our primary objectives. The CMS's GPRA goals reflect quality priorities both in prevention and adhering to quality standards and support the Department's strategic plan goals. Several of the QIOs' national quality priorities are reflected in our performance goals. These health conditions represent those that impact a large number of our beneficiaries and impose a significant burden on the health care system. For example, an estimated 780,000 surgeries are complicated by infection each year resulting in longer hospital stays, increased morbidity, mortality, and health care costs. Therefore, our new goal to prevent surgical site infections focuses on administering antibiotics in a timely manner before a surgical procedure.

Heart Attack Survival - The ambitious goal to increase the 1-year survival rate among beneficiaries who suffer a heart attack illustrates CMS's partnerships with the QIOs to help improve the quality of care for our beneficiaries. This nationwide effort focuses on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks. The impact of these improvements may be especially dramatic in areas where providers have not fully introduced these lifesaving measures.

We did not meet our FY 2000 goal to decrease the one-year mortality rate to 27.4 percent among Medicare beneficiaries following hospital admissions for heart attack. In fact, the one-year mortality rate for heart attacks that occurred between August 1, 1999 and July 31, 2000 was 33.2 percent (an increase over the rate for the previous year of 32.3 percent). Based on this data and other recent trends, we do not expect to meet the FYs 2001 and 2002 targets.

There are a number of interventions that have been proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. The CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

Adult Immunizations - Our performance goals on adult immunizations (annual influenza and lifetime pneumococcal) are examples of CMS's promotion of preventive health. Complications arising from pneumococcal disease and influenza kill more than 30,000 people a year in the United States -- typically resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza.

In recent years, there have been flu vaccine shortages and distribution delays, which have impacted the delivery of immunizations. The inability to quantify the impact of these shortages to date reduces the confidence we have in achieving our targets for the affected years, and for reliably setting future targets. Also, data analyses from different sources point to an apparent leveling off of flu vaccination rates, and most recent data for pneumococcal vaccinations indicate that these rates are slowing down as well.

In FY 2001, 67.4 percent of all Medicare beneficiaries age 65 years and older reported receipt of an annual flu vaccine, and 63.3 percent reported receipt of a pneumococcal vaccine in their lifetime. While we exceeded our target to achieve a 63 percent lifetime pneumococcal vaccination rate, we did not meet our target to achieve an annual flu vaccination rate of 72 percent. This decrease in the influenza vaccine rate reflects the

temporary shortage and distribution delays that affected the vaccine distribution in 2000 and 2001, which were beyond our control.

The CMS and the CDC are still actively addressing the unknown impact of the 2000 and 2001 flu vaccine shortages and delayed delivery on our adult immunization performance measures and are closely monitoring recent trends, especially given the growing number of challenges we face in achieving this goal. Our targets for FYs 2002 – 2004 have been set based on the recent trends. In light of recent trends for pneumococcal, we are revising our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older.

The CMS will continue to promote the receipt of annual influenza and lifetime pneumococcal vaccinations. We hope that the recent establishment of standing orders for flu and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies will help to overcome some of the barriers that prevent patients from being immunized.

Mammography – The CMS's performance goal to increase the percentage of women Medicare beneficiaries age 65 and older who receive a mammogram is another illustration of our Agency's promotion of secondary prevention and increasing cancer survival through early detection. Performance measurement of mammography rates has served to focus resources within CMS for ongoing monitoring and improved performance.

Final 2000 NHIS data show that we surpassed our FY 2000 target of 60 percent of women age 65 and older to receive a biennial mammogram by reaching 68.1 percent (the FY 2000 target was measured using NHIS data). We are also pleased to report that we have surpassed our FY 2001 target of 51 percent of women age 65 years and older to receive a mammogram by reaching 51.6 percent. FY 2001 marks the first year CMS used Medicare claims data (National Claims History File) to measure this goal.

The CMS's FY 2001 and FY 2002 mammography targets are based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised their technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 Technical Specifications. The revised indicator reflects changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.

The CMS's revised mammography indicator is a more restrictive definition than is the current indicator. Reanalysis of biennial 2000-01 mammography data with this "HEDIS® 2002" mammography measure suggest a decrease of 0.6 percent of eligible female beneficiaries age 65 years or older with mammography services paid by Medicare. Consequently, future targets for CMS's mammography goal have been revised, beginning with FY 2003, to account for the more conservative estimates from the HEDIS® 2002

measure. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

In late 2001-early 2002, there was a great deal of controversy in the press regarding mammography, along with press releases from governmental agencies affirming the recommendations for regular mammography screening. For example, the US Preventive Services Task Force (USPSTF) and the National Cancer Institute (NCI) continue to recommend mammography for early detection. Additionally, the Department of Health and Human Services issued a press release affirming the need for mammography screening. Continued outreach and education may be especially important at this time to ensure that women with Medicare get screening mammograms on a regular basis. The CMS remains committed to its mammography efforts.

Diabetic Eye Exams - Diabetes is another highly prevalent condition in the Medicare population. Many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring and treatment. The CMS's quality goal to increase special eye exams for our diabetic beneficiaries reflects our commitment to improve diabetes care.

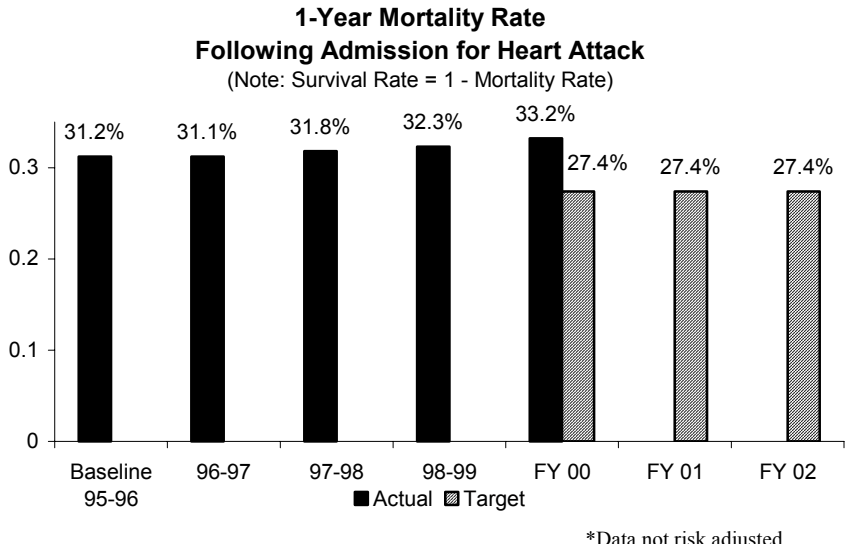
We surpassed our FY 2001 goal to increase the rate of biennial diabetic eye exams to 68.3 percent by increasing the rate to 68.9 percent. Based on the progress we have seen thus far, we anticipate continued success with this goal.

Surgical Site Infections – Optimizing the timing of antibiotic administration has been demonstrated to decrease the incidence of surgical site infection. The addition of this goal in our performance plan is another example of our commitment to preventive health and increasing healthy outcomes for our beneficiaries.

The Medicare Surgical Site Infection Prevention Project (SIP) is currently being implemented in 19 States and will be expanded nationally by February 1, 2003. While the SIP Project focuses on the five highest volume surgeries, CMS will only be targeting the total percentage increase in frequency from all the cases followed. Baseline data from 2001 demonstrated that antibiotics were only administered within the recommended timeframe in less than half (47.4 percent) the cases. With national expansion and continued QIO commitment our targets for FY 2003 and FY 2004 increase to 49.8 percent and 54.8 percent respectively, significantly reducing the number of complications our beneficiaries will experience.

Performance Goal QIO1-02

Improve Heart Attack Survival Rates
By Decreasing Mortality
(Discontinued after FY 2002)



The 1995-96 national baseline 1-year mortality rate among Medicare beneficiaries hospitalized for heart attack was 31.2 percent (corrected from previously-noted 31.4) based on hospital admissions for heart attack August 1995-July 1996. Rates calculated by CMS from Medicare Part A hospital claims and Medicare enrollment database**.**

Discussion: Improving treatment for heart attack has been a focus of CMS's Health Care Quality Improvement Program (HCQIP) since its inception in 1992. The CMS has been working to improve survival (by working to reduce deaths) from heart attack by assisting hospitals to improve their adherence to the following consensus-based treatment guidelines:

- Aspirin administered early in the hospital course (decreases clotting of the blood);
- Beta Blocker administered early in the hospital course (decreases heart's workload and oxygen need);
- Timely initiation of therapy to try to open blocked arteries in the heart (reperfusion therapy);
- Smoking cessation counseling during hospitalization;
- Aspirin prescribed at discharge;
- Beta Blocker prescribed at discharge; and
- Angiotensin Converting Enzyme (ACE) Inhibitor prescribed at discharge (reduces blood pressure) if the heart's pump function is impaired.

During the 1995-96 baseline period (August 1995 to July 1996) approximately 31.2 percent of Medicare beneficiaries hospitalized for heart attack died within a year. Since many patients were appropriate candidates for all or some of the treatments listed above, CMS anticipated that patient survival following a heart attack could be improved

by more widespread use of these proven therapies. The American College of Cardiology and the American Heart Association also initiated efforts to increase the use of these recommended treatments, all of which are included in their published guidelines.

Target rates for this goal were derived from data generated in a four-State pilot quality improvement effort conducted by Quality Improvement Organizations (QIOs) during 1994 through January 1995 to improve statewide rates focused on heart attack treatment. One-year mortality following heart attack was reduced by about one percentage point more than in other States. Starting in 1996, CMS expanded these efforts, and QIOs nationwide began to phase in quality improvement activities related to heart attack treatment. In 1999, CMS began writing performance-based contracts with QIOs, and we will be evaluating them on State-level improvement on these interventions.

The background rate of improvement in survival that occurred in the States not involved in the pilot project averaged about 0.6 percentage points per year. If this trend were to continue, the expected change after 5 years would be 3.0 percentage points. Therefore, the target assumed that this trend would continue; though this was somewhat uncertain and difficult to verify. A national intervention similar to the pilot project would be expected to improve 1-year mortality after heart attack by about 1 percentage point once the interventions had been widely adopted; all QIOs initiated these efforts by late FY 2000. Since approximately 323,000 Medicare beneficiaries are hospitalized for heart attacks per year (data from August 1995 through July 1996), a decrease of one percentage point would translate into about 3,000 lives saved.

There are a number of interventions that have been proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. The CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

Coordination: The CMS has worked with the National Heart, Lung, and Blood Institute, the American College of Cardiology, the American Heart Association, the American Medical Association, the American Hospital Association, and multiple other organizations during the foundational stages of these efforts, and continues its partnerships with a number of these organizations. The CMS will also continue its ongoing collaboration around HCQIP with the QIOs.

Data Source(s): The mortality rates are calculated from Medicare Part A hospital claims and the Medicare Enrollment Database. Since mortality data for the year following hospitalization are needed, there will be a lag in reporting results. For example, in order to know the 1-year mortality rate for patients hospitalized in August 2000 through July 2001, deaths occurring during August 2001 through July 2002 would need to be assessed.

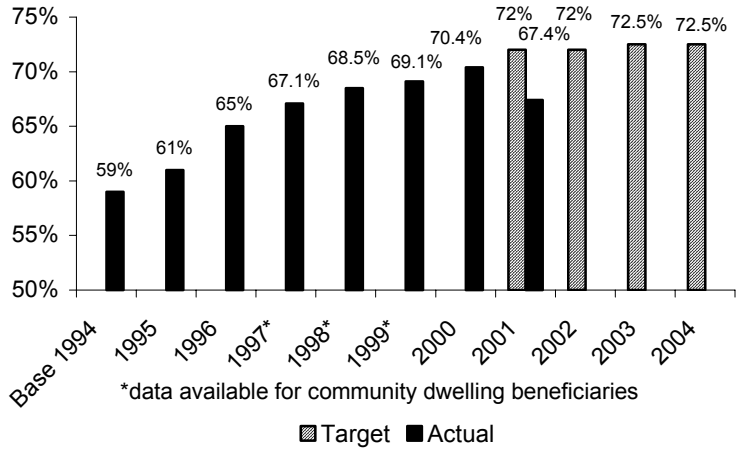
After updating the enrollment database, linking to the claims data, and performing the analysis, results would be expected in FY 2003. Neither the actual nor target rates have been adjusted for age or co morbidity, both of which may markedly affect the mortality rate.

Verification and Validation: The Medicare eligibility file is derived from Social Security information, which is used as a basis for Social Security payments. Death data are validated against the National Mortality Index.

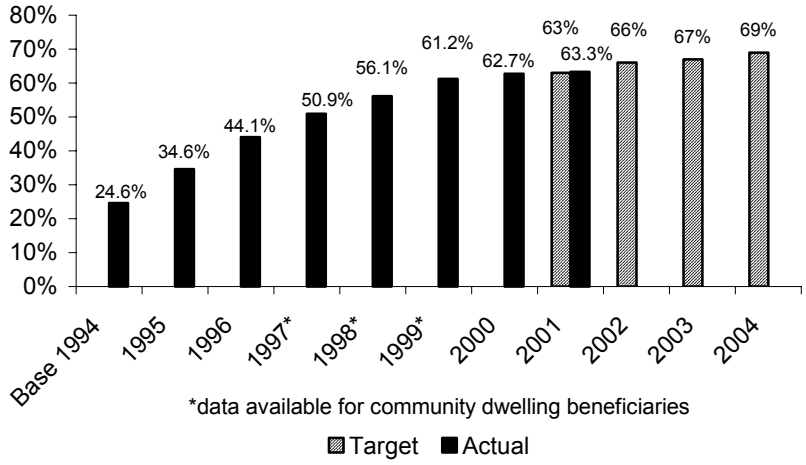
Performance Goal QIO2-04

Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal

Receipt of Influenza Vaccination Age 65 and Older (MCBS)



Receipt of Lifetime Pneumococcal Vaccination Age 65 and Older (MCBS)



Discussion: Complications arising from pneumococcal disease and influenza kill more than 30,000 people a year in the United States -- typically resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza. Consistent with the Department's strategic plan goals and

through the collaborative efforts of CMS, the Centers for Disease Control and Prevention (CDC) and the National Coalition for Adult Immunization (NCAI), we are working to improve adult immunization rates in the Medicare population.

In recent years, there have been flu vaccine shortages and distribution delays, which have impacted the delivery of immunizations. The inability to quantify the impact of these shortages to date reduces the confidence we have in achieving our targets for the affected years, and for reliably setting future targets. Also, data analyses from different sources point to an apparent leveling off of flu vaccination rates, and most recent data for pneumococcal vaccinations indicate that these rates are slowing down as well.

Other challenges CMS faces in achieving our adult immunization goal include the following:

- The current reimbursement rate for vaccinations is considered too low by many providers, who are increasingly not offering this service;
- One of the largest manufacturers of influenza vaccines has recently dropped out of the market, with as yet unknown impact on production levels;
- Public concern about the general safety of immunizations has recently been fueled by reports of potential side-effects of the smallpox vaccine, with unknown consequences on compliance levels in our target population; and
- Pneumococcal vaccinations are still not universally accepted by providers.

The most effective strategy noted in current literature for improving patient access to adult immunizations is the implementation of standing orders. This occurs when non-physician personnel vaccinate according to a protocol without direct physician involvement at the time of immunization. To support this evidence-based intervention, CMS and the CDC have been working together to develop a strategy to increase the use of standing orders for influenza and pneumococcal vaccinations. In October 2002, standing orders were established for influenza and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies that serve Medicare and Medicaid beneficiaries.

The CMS and the CDC are also still actively addressing the unknown impact of the 2000 and 2001 flu vaccine shortages and delayed delivery on our adult immunization performance measures and are closely monitoring recent trends, especially given the growing number of challenges we face in achieving this goal.

Our targets for FYs 2002 - 2004 have been set based on the recent trends. In light of recent trends for pneumococcal, we are revising our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older.

Coordination: The CMS, CDC and NCAI have formulated a long-term, structured campaign to increase the rate of influenza and pneumococcal vaccination among the Medicare population. One aspect of the campaign promotes the benefits of an annual

influenza and lifetime pneumococcal vaccination directly to Medicare beneficiaries. This aspect of the campaign has been conducted via direct mail emphasizing Medicare coverage and the medical benefits of vaccinations. Another aspect of the campaign targets health care providers and focuses on interventions designed to minimize missed opportunities for immunization status assessment and vaccination.

Quality Improvement Organizations (QIOs) are working in collaboration with beneficiaries, providers, managed care plans, community groups and other interested partners to design and implement immunization quality improvement projects. These projects are conducted in hospitals, long-term care facilities, dialysis facilities, physician offices, home health agencies and public health clinics. They combine education for healthcare workers, a plan for identifying high-risk patients, and efforts to remove administrative and financial barriers that prevent patients from receiving the influenza and pneumococcal vaccines.

Data Source(s): In FY 2001, the Medicare Current Beneficiary Survey (MCBS) was designated as the primary data source for this goal. The MCBS is an ongoing survey of a representative national sample of the Medicare population, including beneficiaries who reside in long-term-care facilities.

The National Health Interview Survey (NHIS), an annual national household interview of non-institutionalized persons, was designated as the primary data source for this goal through FY 2000. Limitations to the continued use of the NHIS as the primary data source include: (1) time lags between collecting and reporting NHIS data, and (2) exclusion of Medicare beneficiaries who reside in long-term care facilities.

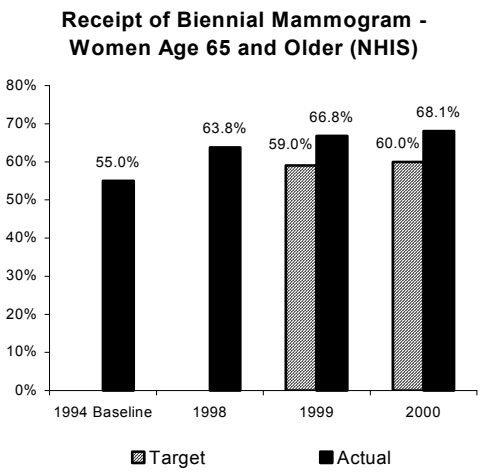
The NHIS and the Behavioral Risk Factor Surveillance System (BRFSS) provide comparable data to the MCBS, for community-dwelling persons age 65 or older, and will be used as secondary data sources

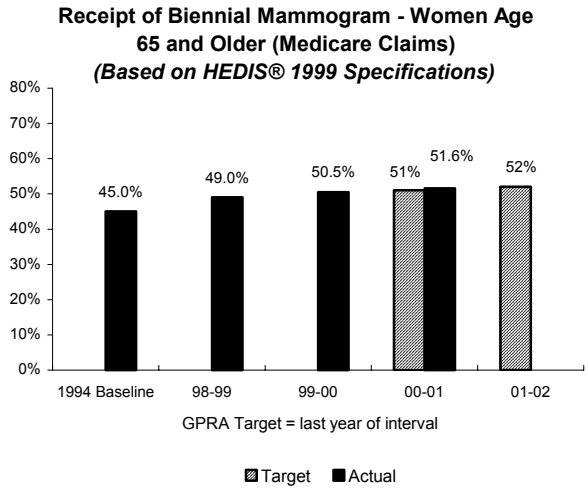
Medicare claims data (National Claims History file) provide another supplementary source of data but are likely to under-report vaccinations because the data exclude Medicare beneficiaries enrolled in managed care plans and beneficiaries who receive vaccinations outside the Medicare payment system (e.g., free clinics). Nevertheless, the information does provide great detail relating to demography, providers, geography, and vaccination opportunities missed.

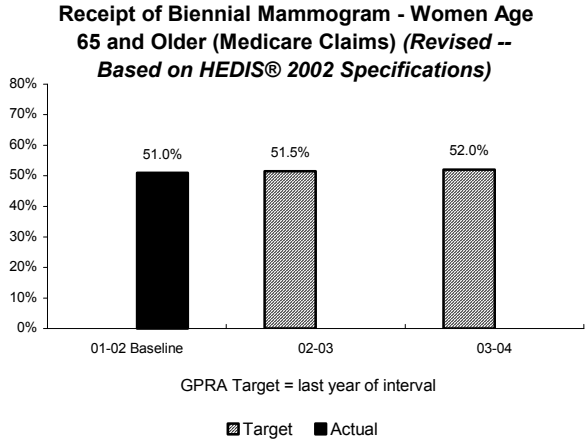
Verification and Validation: The MCBS uses Computer Assisted Personal Interview (CAPI) technology to perform data edits, e.g., range and integrity checks, and logical checks during the interview. After the interview, consistency of responses is further examined and interviewer comments are reviewed.

Performance QIO3-04

Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram







Discussion: CMS's National Medicare Mammography Campaign is directed at improving women beneficiaries' knowledge of breast cancer screening and awareness of Medicare's annual screening mammography benefit. Health care providers are also targeted to improve their recommendation of breast cancer screening.

In support of the Mammography Campaign, CMS's goal is to increase the percentage of Medicare women age 65 and over who receive a mammogram every two years. By taking advantage of the lifesaving potential of mammography, we hope to ultimately decrease mortality from breast cancer in the Medicare population. Women over 65 face a greater risk of developing breast cancer than younger women, and a disproportionate number of breast cancer deaths occur among older African-American women. Encouraging breast cancer screening, including regular mammograms, is critical to reducing breast cancer deaths for these populations. The enactment of the Balanced

Budget Act of 1997 expanded Medicare coverage to include annual screening mammograms for all Medicare eligible women effective January 1, 1998 and eliminated the part B deductible. Effective April 1, 2001, enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded Medicare coverage to include digital mammograms.

The CMS's FY 2001 and FY 2002 mammography targets are based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised their technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 Technical Specifications. Based on these recent revisions, we have modified our baseline and future targets, beginning with FY 2003, to attain consistency with the 2002 HEDIS® measure and to reflect changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.

The CMS's revised mammography indicator is a more restrictive definition than is the current indicator. Analysis of the HEDIS® 2002 measure yields a mammography rate that is 0.6 percent lower for FY 2001 than is attained using our previous HEDIS® 1999 measure of eligible female beneficiaries age 65 years or older with mammography services paid by Medicare. Consequently, future targets for CMS's mammography goal have been revised, beginning with FY 2003, to account for the more conservative estimates from the HEDIS® 2002 measure. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

Coordination: The CMS has undertaken a National Medicare Mammography Campaign to increase awareness of the importance of regularly scheduled mammograms and the annual Medicare mammography benefit among Medicare women. This campaign relies on a variety of partnerships to reach both beneficiaries and providers with these important messages.

CMS's Mammography Campaign involves a number of components within the Agency, including the Center for Beneficiary Choices, the Center for Medicare Management and the Office of Clinical Standards and Quality, as well as CMS's contractors, the QIOs. In addition, the Campaign partners with a number of sister agencies with the Department of Health and Human Services including the National Cancer Institute (NCI), the Centers for Disease Control and Prevention, and the Public Health Service (PHS) Office of Women's Health. Researchers, physicians, and nurses are also consulted on a number of the mammography campaign activities.

The CMS's Quality Improvement Organizations (QIOs) are charged with monitoring and improving quality of care for Medicare beneficiaries. The QIOs are directed to improve mammography rates among female Medicare beneficiaries (in their respective States). The QIOs' contract performance will be evaluated, in part, on measured improvements in their statewide mammography rates. Among many of the mammography campaign activities, CMS and the QIOs have worked with Wal-Mart Stores, Inc. to distribute

mammography educational materials to their pharmacy customers across the country. These educational materials - which include a Medicare message - are produced by CMS in partnership with the National Cancer Institute

Data Source(s): The National Claims History (NCH) file is the data source used to track the mammography goal. The percentage of women age 65 and older with paid Medicare claims for mammography services during a biennial period will be calculated. The denominator consists of women who are enrolled in both Part A and B on a fee-for-service basis. Medicare beneficiaries who are enrolled in an HMO for more than a month in either year of the biennial period will not be included in the rate calculation. The baseline of 45 percent for 1997-98 includes mammography services paid for by Medicare for women ages 65 and older that were not enrolled in managed care.

Secondary data sources include the Medicare Current Beneficiary Survey (MCBS), the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS). The NHIS served as the primary data source for CMS's mammography goal through FY 2000.

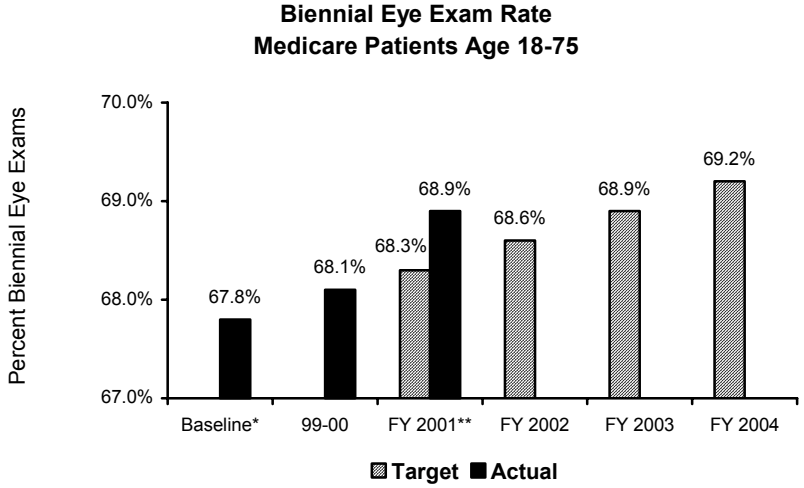
The CMS will continue to monitor recommendations by leading authorities such as the U.S. Preventive Service Task Force regarding the frequency of mammography and targeted age groups. As new developments dictate, CMS's staff will consider modifications to this goal to ensure consistency with evidence-based recommendations for mammography.

Verification and Validation: The NCH is a 100 percent sample of Medicare claims. Claims submitted by providers to Medicare are checked for completeness and consistency. Duplicates are eliminated to ensure that women who have more than one mammogram within the two-year period do not contribute to over counting. Mammography utilization rates for age groups, race and counties are calculated and compared to previous years' data to check for any unusual changes in data values.

The CMS will use these alternate data sources to verify and validate the reported trends that are based on the NCH. The self-reported rates of mammography screening have historically been higher when based on these survey sources. Therefore, we cannot directly compare the rates from the secondary data sources with the reported rate based on claims data, but will compare year-to-year changes observed in each data source, to determine if equivalent rates of improvement are seen.

Performance Goal QIO4-04

Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams



* Baseline Revised from 68.5%
** FY 2001 target recalculated from 69.0%

Discussion: Diabetes is a major public health problem and is becoming more prevalent in all age groups. The increasing prevalence is attributed both to higher detection and to poorer health habits (increased rates of obesity being the primary culprit). According to the Centers for Disease Control and Prevention (CDC), prevalence of diagnosed diabetes increased in all age groups between 1980 and 1999, with people ages 65-74 years having the highest prevalence rate (14.51 per 100 population). The rate was 13 times higher than people less than 45 years of age (1.10 per 100 population). Among U.S. adults, diagnosed diabetes increased 40 percent from 1990 to 2000.

The National Eye Institute reports that diabetes affects approximately 14 million Americans, and about 40 percent of all people with diabetes have at least mild signs of diabetic retinopathy, the most common ocular complication of diabetes. Diabetic retinopathy is the leading cause of blindness in adults 25-74 years of age. People with diabetes are at a significantly higher risk of blindness than the general population. Up to 21 percent of newly diagnosed patients with Type 2 diabetes have retinopathy, and many develop some retinopathy over time. Screening and care can prevent up to 90 percent of diabetes-related blindness.

Coordination: The CMS has worked with the American Diabetes Association, the CDC, the Department of Veterans Affairs, the National Committee for Quality Assurance (NCQA) and many others in the development of this goal. The CMS has directed the Quality Improvement Organizations (QIOs) to improve the diabetic eye exam rate among Medicare beneficiaries in their respective States.

The CMS has joined forces with the American Academy of Ophthalmology and the American Optometric Association to launch a national eye care campaign, which includes mailings to beneficiaries, a national outreach campaign with television star Bill Cosby as the spokesperson, and articles in popular and professional sources. Local QIOs have also contributed to the national campaign.

Data Source(s): The National Claims History (NCH) file will be the primary data source. The percentage of diabetics ages 18-75 with paid Medicare claims for a retinal exam during a biennial period will be calculated. An age range 18-75 was selected in order to be consistent with the Health Plan Employer Data Information Set (HEDIS®) comprehensive diabetes measure used widely in managed care. The denominator consists of diabetics who are enrolled in both Part A and B on a fee-for-service basis. Medicare beneficiaries who are enrolled in a health maintenance organization (HMO) for more than a month in either year of the biennial period will not be included in the calculation of the rate.

The biennial baseline is based on Medicare claims data for 2 million diabetic beneficiaries. The measurement period varied depending on an individual State's QIO contract cycle. Each State fell into one of three measurement periods. The first period covered calendar years: 1997 and 1998; second: April 1, 1997 - March 31, 1999; third: July 1, 1997 - June 30, 1999. Future biennial rates will be calculated in a similar manner. A programming error required a revision of the 1997-99 baseline from 68.5 percent to 67.8 percent.

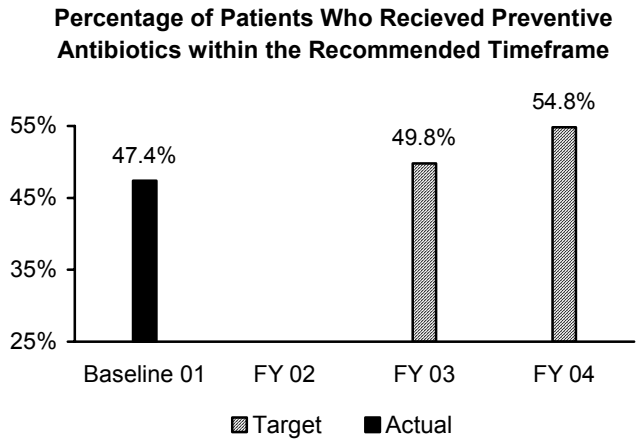
Secondary data sources include the NCQA HEDIS® data set and the NHIS. The NCQA HEDIS® data set is an annual survey of individual managed care plans. All Medicare+Choice plans are required to collect and report the rate of eye exams for their Medicare members who have diabetes. The NHIS is an annual national household interview of community-dwelling persons. The CMS will use these alternate data sources to verify and validate trends.

Verification and Validation: The NCH is a 100 percent sample of Medicare claims submitted by providers to Medicare and is checked for completeness and consistency. Utilization rates for age groups, race and gender are calculated and compared to previous years' data to check for any unusual changes in data values.

Medicare+Choice plans' HEDIS® data must be audited each year by an independent contract. These contractors implement a standard audit protocol that has been developed and tested by the NCQA, in conjunction with CMS. The NHIS is a validated survey which uses electronic data range checks and internal consistency checks.

Performance Goal QIO5-04

Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection



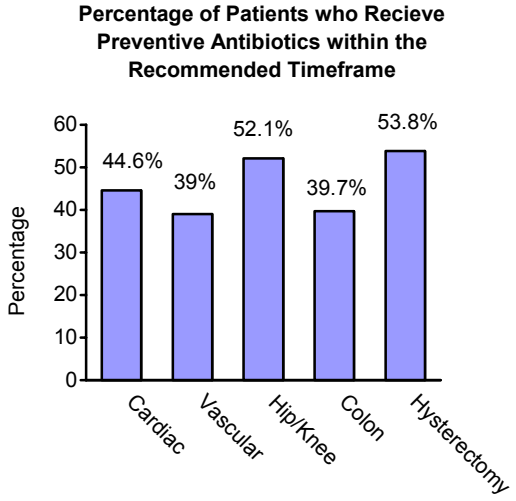
Discussion: Postoperative surgical site infection (SSI) is a major cause of patient morbidity, mortality, and health care cost. SSI complicates an estimated 780,000 of nearly 30 million operations in the United States each year. For certain types of operation, rates of infection are reported as high as 20 percent. Each infection is estimated to increase hospital stay by an average of 7 days and add an average of over $3,000 in hospital costs (1992 data). The incidence of infection increases intensive care unit admission by 60 percent, the risk of hospital readmission five-fold, and doubles the risk of death. Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection.

The goal of administering the antibiotic before surgery is to establish an effective level of the antibiotic in the body to prevent the establishment of infection during the time that the surgical incision is open. Studies performed in the 1960's and 1970's demonstrated that a common reason why the prevention failed was because the antibiotics were administered too far ahead of surgery (resulting in diminished antibiotic levels towards the end of surgery) or after the operation began (resulting in an absence of antibiotics towards the beginning of surgery). In a study of 2,847 surgery patients at The Latter Day Saints (LDS) Hospital in Salt Lake City, Classen, et al. found that the lowest incidence of post-operative infection was associated with antibiotic administration within one hour prior to surgery. The risk of infection increased progressively with greater time intervals between administration and skin incision. This relationship was observed whether antibiotics preceded or followed skin incision.

Opportunities to improve postoperative care have been demonstrated. The actual systems within hospitals are often the cause of improper antibiotic timing. For example, at LDS Hospital, administration of the first antibiotic dose "on call" to the operating room was frequently associated with the antibiotic being administered too early. Restructuring the

system resulted in an increase in appropriate timing from 40 percent of cases in 1985 to 99 percent of cases in 1998.

The Centers for Medicare & Medicaid Services (CMS) has been developing the national Medicare Surgical Infection Prevention (SIP) Project, www.surgicalinfectionprevention.org , since 1999. The SIP Project measures the frequency of antibiotic administration within the hour prior to five common types of major surgery where infection is the most likely to occur (see below). The chart below shows the number of cases where antibiotics were administered within the hour prior to surgery compared to the number of cases followed (i.e. numerator/denominator). The data from FY 01 will be the baseline from which future years will be measured. While the data being collected have specific targets for the individual surgeries, CMS will only be reporting on the percentage of proper administration for the total of all five types of surgery.



Type of Surgery	# Patients receiving antibiotics within timeframe/ # of surgeries (baseline FY 01)
Cardiac	1556/3486
Vascular	561/1440
Hip/knee	3649/7000
Colon	944/2378
Hysterectomy	651/1211
Total	7361/15515

Coordination: The Centers for Disease Control and Prevention (CDC) has been a major partner in this project. The project will be implemented by the Medicare quality improvement organizations (QIOs) during the seventh contract cycle, which began for 19 States on August 1, 2002. The project will be implemented in all States by February 1, 2003.

The CMS and CDC have formed partnerships with 13 outside organizations to support the project. These include the American Academy of Orthopedic Surgeons, the American College of Surgeons, the American Geriatrics Society, the American Hospital Association, the American Society of Anesthesiologists, the American Society of Health Systems Pharmacists, the Association of Perioperative Registered Nurses, the Association for Professionals in Infection Control and Epidemiology, the Infectious Diseases Society of America, the Joint Commission on Accreditation of Healthcare Organizations, the Society for Healthcare Epidemiology, the Surgical Infections Society, the Voluntary Hospital Association, the Society of Thoracic Surgeons, and Premier, Inc. The Oklahoma Foundation for Medical Quality was contracted as the support QIO for the

project. A SIP collaborative that applies the quality improvement methods of the Institute for Healthcare Improvement is in progress in all 50 States.

Data Source: Baseline State-level performance rates are calculated using data abstracted from up to 870 medical records sampled randomly in each State. Ongoing surveillance sampling will take place through the entire QIO contract period. Data are collected by two clinical data abstraction centers that have been under contract with CMS for 7 years. An abstraction tool designed specifically for that purpose will support data collection by hospitals.

Verification and Validation: The accuracy and reliability of data from the abstraction centers are monitored constantly through reabstraction of a sample of medical records. If the data collected by hospitals are used by CMS, the data will then be validated by each State's QIO and/or the clinical data abstraction centers.

Quality of Care:
Survey and Certification

Survey and Certification Program	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	**$242.1 M**	**$253.1M**	**$247.6 M**	**$247.6 M**

The State Survey and Certification program ensures that institutions providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety, and quality standards. Institutions covered include hospitals, nursing homes, home health agencies (HHAs), end-stage renal disease (ESRD) facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries. The CMS's investment in quality oversight includes initial inspections of providers who request participation in the Medicare program, annual recertification inspections, and visits in response to complaints. The survey and certification budget includes funds to strengthen and continue activities focused on ensuring that our beneficiaries in nursing homes receive quality care in a safe environment. As part of CMS's Nursing Home Oversight Improvement Program, surveyors have been instructed to pay particular attention to nursing homes' use of physical restraints and to their ability to prevent and treat pressure ulcers. In addition, CMS's public reporting initiatives have provided new information to consumers about these measures. For example, the Nursing Home Compare website (www.medicare.gov/nhcompare/home.asp) gives consumers access to this information on the Internet.

Performance Goals	Targets	Actual Performance	Ref.
Decrease the Prevalence of Restraints in Nursing Homes	**FY 04:** 10% **FY 03:** 10% **FY 02:** 10% **FY 01:** 10% **FY 00:** 10% **FY 99:** 14%	**FY 04:** **FY 03**: Final Data expected 3/04 **FY 02:** Final Data expected 3/03 **FY 01:** 10.0% (Goal met) **(NEW DATA)** **FY 00:** 10.0% (Goal met) **FY 99:** 11.9% (Goal met) **FY 96:** 17.2% **(Baseline)**	QSC1 **3,5**
Decrease the Prevalence of Pressure Ulcers in Nursing Homes	**FY 04:** 9.5% **FY 03:** 9.5% **FY 02:** 9.5% **FY 01:** 9.6 % **FY 00:** Establish baseline/targets	**FY 04:** **FY 03:** Final Data expected 3/04 **FY 02:** Final Data expected 3/03 **FY 01:** 10.5% (Goal not met) **(NEW DATA)** **FY 00:** 9.8% (Goal met) **(Baseline)**	QSC2 **3,5**

Performance Goals	Targets	Actual Performance	Ref.
Improve the Management of the Survey and Certification Budget Development and Execution Process			QSC3 See FY 03 Revised Final
-- Use price based methodology to allocate survey and certification appropriation	**FY 04:** Allocate FY 2004 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC and/or NLTC surveys	**FY 04:**	
	FY 03: Allocate FY 2003 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC and/or NLTC surveys	**FY 03:**	
	FY 02: Allocate FY 2002 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC surveys	**FY 02:** (Goal met)	
	FY 01: Allocate FY 2001 budget increases to those States within the 15% threshold for unit survey hours	**FY 01:** (Goal met)	
-- Use performance measures and baselines to measure quality of survey work performed	**FY 04:** Assure FY 03 standards are met and identify appropriate corrective action plans	**FY 04:**	
	FY 03: Assure FY 02 standards are met and identify appropriate corrective action plans	**FY 03:**	
	FY 02: Evaluate FY 01 performance results	**FY 02:** (Goal met)	
	FY 01: Develop measures	**FY 01:** Measures developed (Goal met)	

Performance Results Discussion

The core of the nursing home survey process is a 4-5 day onsite visit that checks to see that a nursing home is meeting Federal health and safety requirements. The standard survey takes a "snapshot" of beneficiary care. They are unannounced and, by legislation, must take place based on a statewide average of once every 12 - 15 months. Also, States

must conduct complaint surveys within proscribed time frames any time a serious problem is alleged.

The CMS monitors specific data reported by nursing homes such as the Minimum Data Set (MDS) and the administrative data from the Online Survey Certification and Reporting System (OSCAR) and uses these aggregate data sets to provide a comprehensive view of the individual receiving care in the nursing home. State Survey and Certification Agencies focus on quality of care furnished to residents as measured by indicators of medical, nursing and rehabilitative care, dietary and nutrition services, activities and social participation, sanitation, infection control, and the physical environment. Our performance goals to improve the rates of physical restraints and pressure ulcers in nursing homes represent the Agency's commitment to protect its beneficiaries.

We know that targeted quality improvement initiatives improve the quality of care and Medicare Quality Improvement Organizations (QIOs) are leaders in these efforts. Quality improvement in nursing homes is a major focus of the QIOs under the 7th Scope of Work (SOW). In fact, the QIOs will be supporting CMS's efforts to publicly report the quality of care in nursing homes. The Nursing Home Quality Initiative is a multi-pronged effort that consists of 1) CMS's continuing regulatory and enforcement initiatives conducted by State survey agencies; 2) new and better consumer information on the quality of care in nursing homes; 3) community-based quality improvement programs offered by QIOs; and 4) collaboration and partnership to leverage knowledge and resources. QIOs will work with nursing home providers to improve performance on agreed upon measures and to implement quality improvement projects and will work with the stakeholders, including the State Survey & Certification agencies to improve care. Together, these activities will help us achieve our annual nursing home performance goals.

For now, CMS will maintain the targets for FY 2004 nursing home quality goals while we carefully assess trends and explore alternate measurement approaches for these goals.

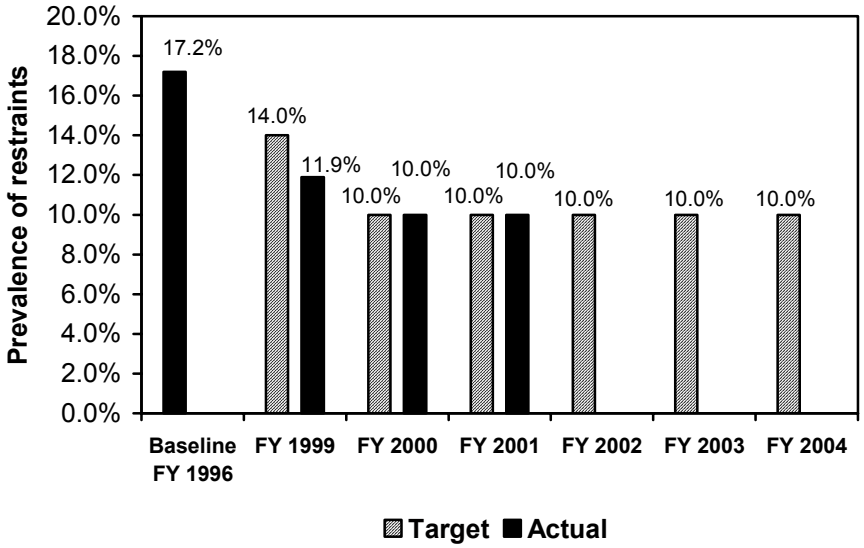
Physical Restraints - The CMS's efforts to reduce the use of physical restraints through the State Survey and Certification Program have been successful. Use of restraints in nursing homes has decreased from 17.2 percent in 1996 to 10.0 percent in 2001, and we achieved our FY 2001 target. Although we have achieved a large reduction in the use of physical restraints in recent years, we believe that current program efforts are achieving smaller reductions in restraint use than they have previously. Interim FY 2002 data (September 2002) was 9.8 percent; final data for this goal is expected in early 2003. The CMS is exploring ways to further reduce physical restraints as we maintain the current target at 10 percent.

Pressure Ulcers – The CMS is concerned about the increase in pressure ulcer prevalence over the FY 2000 baseline and about the gap between the target and the measured rate. We did not meet our FY 2001 target of 9.6 percent, since reported rates were at 10.5 percent. The interim performance for FY 2002 is 10.4 percent (September 2002) against a target of 9.5 percent; final performance results will be available in early 2003. We believe that this increase in prevalence may stem in part from a number of factors: an artifactual effect due to facilities' change in coding behavior resulting in reporting of pressure ulcers that would not previously have been reported; and an increase in case-mix (severity of illness) of the nursing home population. We are working to better understand and address these variables. Also, we are developing a program to educate providers about more accurate assessment and coding, as well as new protocols aimed at onsite audit procedures that will verify the accuracy of nursing homes' Minimum Data Set (MDS) assessments. We are maintaining our target of 9.5 percent, as we reevaluate our future methodology for this performance goal.

Survey and Certification Budget – Our goal to improve the survey and certification budget process moved CMS from the "cost" based approach to a "price" based methodology, which uses national standard measures of workload and costs to project individual State workloads and budgets. The CMS met its FY 2002 target to allocate the FY 2002 budget increase to the State Survey and Certification budget using a price-based methodology. The CMS analyzed the combined national average survey times for long term care facilities. Any State that exceeded by 15 percent or more the combined national average survey time for long term care facilities was provided an FY 2002 base budget that assumed the FY 2001 funding level. All other States received a FY 2002 base budget increase proportionate to each State's FY 2001 budget. Also in FY 2002, CMS finalized its FY 2002 performance standards for State survey agencies.

Performance Goal QSC1-04

Decrease the Prevalence of Restraints in Nursing Homes



Discussion: "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. According to the law, restraints can only be imposed to treat the resident's medical symptoms, to ensure safety and only upon the written order of a physician (except in emergency situations). Restraints should never be used for staff convenience or to punish the resident.

The reduction of the use of physical restraints is one of CMS's major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care, and considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

One of the main ways in which CMS can promote reduced use of physical restraints is through the State Survey and Certification Program. State and CMS surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason.

In establishing performance goals for the quality area, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. Individuals in nursing homes are a particularly vulnerable population, and consequently, it is an area of considerable importance. A significant portion of benefit dollars in both Medicare and Medicaid pay for care in nursing homes. Although not yet updated for FY 2002, 19 percent of benefit dollars under Medicaid and nearly 6 percent

for Medicare were associated with nursing home expenditures in FY 2001. In the short term, CMS will continue to maintain a level target of 10 percent for restraints in Nursing Homes. We are evaluating possible effective interventions and measures.

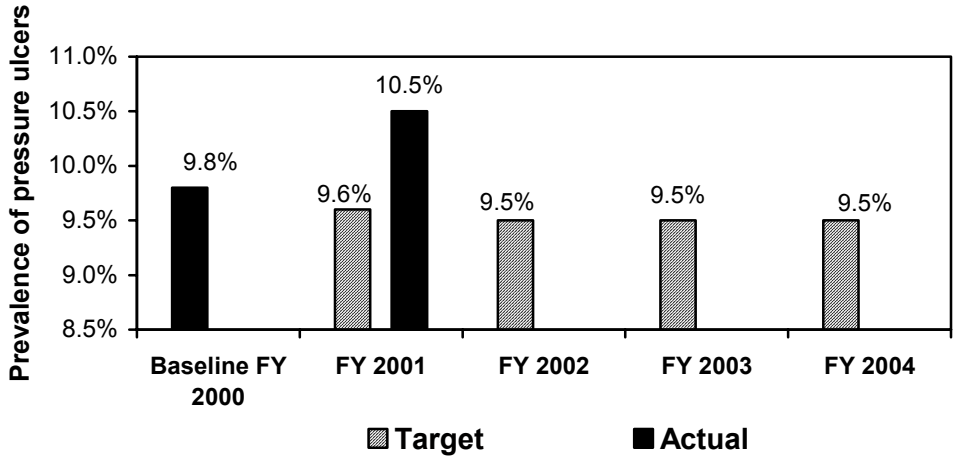
Coordination: The CMS's coordination includes State survey agencies and CMS Regional Offices.

Data Source(s): Currently data on the use of physical restraints are contained in the Online Survey and Certification and Reporting (OSCAR) database. In the future, as the Minimum Data Set (MDS) information becomes more widely available, CMS plans to use these data to further refine this goal.

Verification and Validation: Data are verified during annual, onsite surveys. The measure used for this goal is the prevalence of restraint use at the time of the survey (OSCAR) and is self reported by the facility. During these surveys, surveyors perform resident observations, which include interviews and validation of the number of residents in restraints reported by the facility. During record review, surveyors identify the documentation of the medical symptom and the assessment and care plans associated with physical restraint use.

Performance Goal QSC2-04

Decrease the Prevalence of Pressure Ulcers in Nursing Homes



Discussion: "Pressure ulcer" refers to any lesion caused by unrelieved pressure resulting in damage to underlying tissues. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents except in those whose clinical condition impedes the prevention of pressure ulcer development. Currently, CMS is in the process of revising and enhancing the interpretive guidelines for surveyors to include: adding information regarding the location of current clinical practice guidelines; enhancing the definitions related to pressure ulcer identification; providing an overview of current processes and practices for the prevention and treatment of pressure ulcers; and revising the investigative protocol for determining if pressure ulcer development was avoidable by the facility. In addition, after this information is in final form, it is planned that educational opportunities regarding the final products will be provided to both surveyors and providers utilizing nationally recognized clinical experts in pressure ulcer care. In addition, CMS is working with Quality Improvement Organizations (QIOs) to assist nursing homes with the development and evaluation of quality improvement programs to improve the prevention and treatment of pressure ulcers.

The prevalence of pressure ulcers in nursing homes appears to have decreased slightly from FY 2001 to 2002. The CMS is still concerned about the increase in pressure ulcer prevalence over the FY 2000 baseline and about the gap between the target and the measured rate. The interim performance for this goal is 10.4 percent against a target of 9.5 percent as of September 2002. Final performance results for the FY 2002 pressure ulcer target will be obtained in early 2003. The CMS believes that this increase in prevalence may stem in part from a number of factors, including facilities' change in coding behavior leading to their reporting pressure ulcers that would not previously have been reported and an increase in case-mix (severity of illness) of the nursing home population.

Reduction of facility-acquired pressure sores remains a high priority of the agency. There are a number of ongoing and planned initiatives that we think will lead to surveyors' improved identification of facility quality of care problems and that will help facilities improve their own quality of care. The CMS is developing a program to educate providers about more accurate assessment and coding of residents' conditions, including pressure ulcers. The CMS is also developing protocols, including onsite audit procedures, to assess the accuracy of nursing homes' Minimum Data Set (MDS) assessments. The CMS will continue to evaluate these data to determine whether or not they represent a true increase. For example, the CMS has developed a measure to track facility-acquired pressure ulcers to help differentiate pressure ulcers that develop in other care settings from those that develop in the nursing home. Additionally, CMS has convened a panel of national clinical experts in pressure sore treatment and prevention. These experts have helped CMS revise the interpretive guidelines and investigative protocols used by surveyors and to improve surveyor training.

Coordination: The CMS is actively pursuing participation of nationally recognized clinical experts on pressure ulcer care in our guideline development. The CMS is working with provider organizations, States, and consumer advocates in developing survey instruments and guidelines. In addition, as part of our effort to develop consistent scope and severity guidance, we have invited nationally recognized pressure ulcer experts from Yale University, and from the National Pressure Ulcer Advisory Panel to help us address pressure ulcer issues.

Data Source(s): The CMS will use the MDS, including special reports derived from the database, such as the quality indicator reports; to measure prevalence of pressure ulcers in long term care facilities. This information is submitted to the State MDS database and in turn is captured in the national MDS database. The measure being used for the pressure ulcer goal is one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison (CHSRA) that is derived from MDS assessments. For this goal we report the prevalence of pressure ulcers measured in the last six months of the fiscal year. If the year is not complete, we report the most recent data available. The numerator consists of all residents with a pressure ulcer, stages 1-4 on the most recent assessment and the denominator is all residents. Pressure ulcers counted on admission assessments are excluded.

Verification and Validation: MDS data quality assurance currently consists of reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

Performance Goal QSC3-04

Improve the Management of the Survey and Certification Budget Development and Execution Process

Baseline: Allocate funding based on previous year's costs.
FY 2004 Target: Allocate FY 2004 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and/or non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
FY 2003 Target: Allocate FY 2003 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and/or non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
FY 2002 Target: Allocate the FY 2002 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed. **Performance:** FY 2002 Target met for allocating FY 2002 Survey and Certification budget. The CMS finalized its FY 2002 performance standards for State survey agencies.
FY 2001 Target: Begin moving States towards a price-based methodology by allocating budget increases to those States with unit survey hours that do not exceed 15 percent above the combined national average, for long term care surveys. Allocate FY 2001 budget increases to those States that are within the 15 percent threshold, as appropriate. Develop performance measures and associated baselines that can be used to measure the quality of the survey work performed. **Performance:** FY 2001 Target met for allocating FY 2001 Survey and Certification budget. Performance measures developed.

Discussion: The CMS's primary mission with the survey and certification program is to ensure that the nation's elderly and disabled are receiving high quality care. In order to ensure this high level of care, CMS has a responsibility to purchase high value survey services, verify that the survey services were performed as contracted, and assess the quality of the survey services performed. To accomplish these objectives, CMS moved from a cost-based budget development and execution model to a price-based model. A price-based methodology for developing and allocating survey and certification funding uses national standard measures of workload and costs to project individual State workloads and budgets, in order to move States towards more uniformity and efficiency.

To accomplish these objectives and to help ensure national consistency in the survey and certification budget process, CMS will continue to review and analyze State reported OSCAR 670 data in the area of survey hours reported for long term care facilities. For example, in FY 2002 CMS assumed the FY 2001 State funding levels as the budget base for States. Any increase to a State's FY 2002 base budget was contingent upon CMS's analyses of combined national average survey times for long term care facilities (skilled nursing and dually participating nursing facilities). Specifically, States that were within

15 percent or less of the combined national average survey time were provided with an FY 2002 base budget increase proportionate to each State's FY 2001 budget. Any State that exceeded the 15 percent combined average survey time threshold received a base budget that assumed the FY 2001 funding level.

The CMS will continue to update historical data with State reported Online Survey and Certification and Reporting (OSCAR) data. By focusing on average survey hours as the cornerstone of a price-based methodology, CMS will use national standard measures of workload and costs to project State workloads and budgets for FY 2003.

The CMS finalized its FY 2002 performance standards for State survey agencies. The CMS anticipates that updates to the performance standards will occur on an annual basis.

Coordination: The CMS's coordination includes Survey and Certification Oversight Board (SCOB), Center for Medicaid and State Operations (CMSO), Office of Financial Management (OFM), CMS Regional Offices (ROs), and State survey agencies.

Data Source(s): Workload data obtained from State reported OSCAR data and State Survey and Certification Workload Reports (Form HCFA-434). The budget, expenditure, and baseline data will be obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.

Verification and Validation: OSCAR data are validated annually as part of annual onsite surveys. Form HCFA-434 and Form HCFA-435 data are validated through CMS Regional Office reviews.

Grants to States for Medicaid/Medicaid Agencies

Medicaid Activity	FY 2001 Actual	FY 2002 Actual	FY 2003 Current Estimate	FY 2004 Estimate
Budget Authority	**$129.4 B**	**$147.3 B**	**$162.4 B**	**$176.8 B**

Medicaid is a means tested health care entitlement program financed by States and the Federal Government. Approximately 43 percent of the funding came from the States and 57 percent from the Federal Government in FY 2002. All 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam) have elected to establish Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. Medicaid programs vary widely from State to State.

Another representative goal related to this budget category but not listed in the chart below is:

- Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and Increase Enrollment of Eligible Children in Medicaid (SCHIP1-04)

Performance Goal	Targets	Actual Performance	Ref.
Increase the Percentage of Medicaid Two-Year Old Children Who are Fully Immunized (Developmental)		**(See Appendix B)**	MMA2
-- Group I	**FY 04:** 3-year reporting period complete **FY 03:** Measure State-specific immunization rate-Achieve State target **FY 02:** Measure State-specific immunization rates **FY 01:** Measure State-specific immunization rates **FY 00:** Complete development of State-specific methodologies and baselines	**FY 04:** N/A **FY 03:** **FY 02:** 12 of 16 States have reported second remeasurement. (See Appendix B) **FY 01:** All methodologies, baselines and targets set. 15 of 16 report first remeasurement. (See Appendix B.) **FY 00:** 16 of 16 States completed methodologies and baselines. (See Appendix B) **FY 99:** Identified Group I States and began developing State-specific methodology and baselines	**1, 7**

Performance Goal	Targets	Actual Performance	Ref.
-- Group II	**FY 04:** Measure State-specific immunization rate **FY 03:** Measure State-specific immunization rate **FY 02:** Measure State-specific immunization rate **FY 01:** Establish State-specific baselines and targets **FY 00:** Identify; begin developing State-specific methodologies and baselines	**FY 04:** **FY 03:** **FY 02:** 5 of 10 States have reported first remeasurement. (See Appendix B) **FY 01:** 10 of 10 States complete methodologies and all have reported baselines and targets (See Appendix B) **FY 00:** Identified Group II States and began developing State-specific methodology and baselines	
-- Group III	**FY 04:** Measure State-specific immunization rate. **FY 03:** Measure State-specific immunization rate. **FY 02:** Establish State-specific baselines and targets **FY 01:** Identify; begin developing State-specific methodologies and baselines **FY 00:** N/A	**FY 04:** **FY 03:** **FY 02:** 17 of 24 States complete methodologies and have developed baselines and/or targets. (See Appendix B) **FY 01:** Group III States identified; began developing State-specific methodologies and baselines **FY 00:** N/A	
Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries	**FY 03:** Goal not continued **FY 02:** 56 States/ Territories **FY 01:** 56 States/ Territories **FY 00:** 56 States/ Territories **FY 99:** 27 States	**FY 03:** N/A **FY 02:** 56 States/Territories (Goal met) **FY 01:** 56 States/Territories (Goal met) **FY 00:** 56 States/Territories (Goal met) **FY 99:** 27 States (Goal met) **FY 98:** 12 States **(Baseline)**	MMA3

Performance Goal	Targets	Actual Performance	Ref.
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates.	**FY 04:** Pilot test the finalized CMS PAM Model in up to 25 States and develop final specifications for the model. **FY 03:** Expand the project to 12 States; pilot test the CMS PAM Model in all 12 States. Assess the results of the FY 02 pilot study; develop draft final specifications for the CMS PAM Model to be pilot tested in FY 04. **FY 02:** Pilot study in 9 States. **FY 01:** Pilot study in 2 States.	**FY 04:** **FY 03:** **FY 02:** (Goal met) **FY 01:** **(**Goal not met) **Baseline:** To be determined	MMA4 **8**
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) -- Medicaid	**FY 04:** **(a)** Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format; and **(c)** Collect 2003 data (baseline) from States. **FY 03:** To begin working with States on the PMPP. **(a)** Report on results of the meeting with States and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and **(c)** Initiate action steps for implementing recommendations.	**FY 04:** **FY 03:**	MMA5 See FY 03 Revised Final **5**

Performance Goal	Targets	Actual Performance	Ref.
-- SCHIP	**FY 04: (a)** Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format; and **(c)** Collect 2003 data (baseline) from States. **FY 03:** To begin working with States on the PMPP. **(a)** Report on results of the meeting with States and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; **(c)** Initiate action steps for implementing recommendations; and **(d)** Begin to implement core SCHIP performance measures.	**FY 04:** **FY 03:**	

Performance Results Discussion

Childhood Immunizations - Despite significant challenges, there continues to be real progress in our State partnerships to increase childhood immunization rates for Medicaid two-year olds. The CMS continues to help States focus on this at-risk population by assisting them in developing State-specific measurements of childhood immunization.

Fifty of the fifty-one States eligible to participate in this project continue to work actively to increase the immunization rates of Medicaid two-year old beneficiaries. Maintaining the parameters of the project over five years, as established by each State, is not easily accomplished. Many States have encountered difficulty in continuing their methodologies and have had to find ways to resolve these issues to stay in the project. However, we believe that measuring States' performance through this project has affected immunization rates by providing an opportunity to draw attention to poor immunization rates in some States and focus them on improvement. In States where immunization rates are high, this project validates and highlights their current efforts and gives them an opportunity to continue successful interventions and plan additional interventions to maintain or improve their rate.

Fiscal year 2002 results thus far indicate 75 percent of Group I States reported second remeasurements, 50 percent of Group II States reported first remeasurements and 71 percent of Group III States reported their baselines and/or targets. Details on Group I, II and III States can be found in Appendix B. This Appendix summarizes each State's methodology, relevant definitions, numerical baselines, 3-year targets, and interim remeasurements.

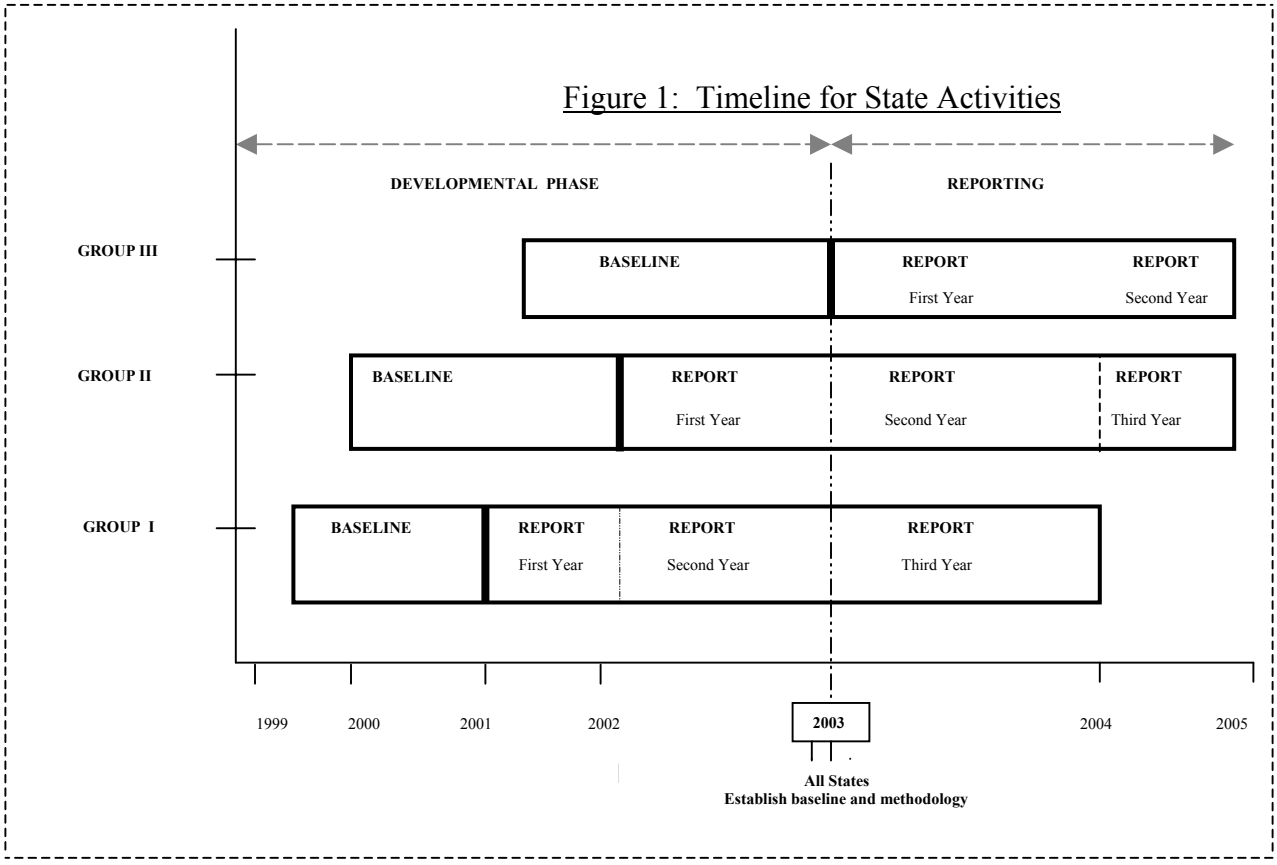
Provide States Linked Medicare and Medicaid Data - The aim of our goal to provide States linked Medicare and Medicaid data files for dually eligible beneficiaries is to enable States to analyze linked Medicaid and Medicare information. In FY 2002, we provided identifiers and made Medicare utilization data available to States. The States will do their own linking with their Medicaid files. This change enables States to match more current Medicaid data rather than use the State Medicaid Research Files (SMRF) that can lag behind two to three years. We met our FY 2002 goal by making Medicare utilization data available to 50 States and 6 Territories. Since FY 1999 CMS has successfully linked Medicare and Medicaid data, and has made Medicare data available to States. The CMS discontinued this goal beginning in FY 2003.

Medicaid Payment Error Rate - The FY 2002 goal to assist States in conducting Medicaid payment accuracy studies seeks to measure and ultimately reduce Medicaid payment error rates. Our FY 2002 target was to work with nine States to conduct payment accuracy studies. The data from these studies would be used to help refine payment accuracy measurement (PAM) methodologies and assess the feasibility of constructing a single methodology usable by all States. The actual pilot studies are being conducted in FY 2002. The CMS contracted with The Lewin Group to work with CMS and the pilot States in FY 2002 and are helping to develop promising Medicaid payment accuracy measurement methodologies for field testing in twelve States during FY 2003. The CMS and The Lewin Group will assess the results from the FY 2002 nine State pilot study and collaborate with the twelve States in FY 2003 in order to develop draft final specifications for the CMS PAM Model to be pilot tested in up to twenty five States in FY 2004.

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) – The CMS is developing a goal to establish formal Federal-State collaborations for improving health care delivery and quality for Medicaid and SCHIP populations using performance measures. In FY 2002, CMS met with States to jointly explore a strategy to effectively use performance measures to quantify and stimulate measurable improvement in delivering quality health care. In FY 2003 we are planning to establish a formal process to develop evidence-based Medicaid health improvement priorities (including performance measure specifications and targeted improvement models). Also in FY 2003, we are planning to implement performance measures in the Medicaid and SCHIP programs and begin collecting baseline data for those measures. In FY 2004, CMS and the States will refine data submission, methodological processes and reporting, and CMS will collect baseline data from the States to begin measuring progress.

Performance Goal MMA2-04

Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized



Discussion: Providing children with the complete series of vaccinations in the first two years of life is a widely accepted public health goal. It is a highly effective intervention to prevent certain diseases, including measles, mumps, rubella (German measles), polio, tetanus, diphtheria, pertussis (whooping cough), and meningitis. Children are required to be immunized in order to enter school and 95 percent or more of American children are adequately vaccinated by kindergarten. However, approximately one million pre-school age children are not adequately protected against possibly fatal illnesses. With increasing numbers of children more readily exposed to infectious disease in day-care settings and elsewhere, complete immunization by age two is critical.

Healthy People 2010 continues to strive for 90 percent immunization coverage level for two-year olds as a national health promotion and disease prevention objective. Currently, 77 percent of two-year olds are fully immunized. However, studies indicate that certain subgroups have much lower coverage rates. The CMS, working in conjunction with the States and the District of Columbia, has developed a three-stage process for its Medicaid Immunization Goal. Figure 1 outlines the time frames associated with the development

of individual State baselines and methodologies for reporting immunization coverage for two-year old children enrolled in Medicaid. The phase-in process of Group I, Group II, and Group III States and their subsequent reporting years are also identified. Once a State has established a baseline, it will set a target for improvement to be achieved after the third year of re-measurement. Quality improvement interventions will also be identified to help reach the target.

During the baseline development years, CMS will work closely with the group of States to assist them with developing a baseline methodology to measure immunization rates of two-year old Medicaid children. Technical assistance will be provided through the Centers for Disease Control and Prevention (CDC) and CMS as determined necessary by States and CMS.

States have a number of options to select as they collect immunization coverage information on two-year old Medicaid children. Since Medicaid is a State-run program, it is best for States to determine how to measure their own immunization rates and to determine their own performance targets. As such, comparisons between States will not be useful or meaningful.

The methodologies chosen by individual States will depend on a number of factors. For example: the service delivery systems used in that State, the existence of functional State or regional registries, and the average duration a Medicaid beneficiary remains enrolled in the program. The baseline measure will define for each State, continuous enrollment in Medicaid, the State's classification of a two-year old, and the State's classification of "fully-immunized." For Medicaid beneficiaries who are in managed care, continuous enrollment refers to enrollment in a specific managed care plan for the specified length of time. For Medicaid beneficiaries in primary care case management (PCCM) and fee-for-service (FFS), it refers to continuous enrollment in the Medicaid program for the specified length of time.

The original development timeline for the goal allotted one year for development and reporting of baseline measures for the States. After working with Group I States for a year, it became evident that more time would be needed by States to fully develop both their measurement methodologies. Reasons for the extension include variations in State reporting cycles for immunization data, data problems, and staff and resource limitations.

Coordination: The CMS has worked closely with States, the CDC, and the American Public Human Services Association (APHSA) to develop a strategy for this goal. APHSA will continue to act as a liaison between the States and CMS. The CDC will continue to partner with CMS, as we provide technical assistance to all States over the course of this goal. The Value-Based Purchasing Group, comprised of State Medicaid Directors and representatives of CMS senior management, have distributed an Immunization Resource Guide to Medicaid Directors. This guide supports the immunization goal by providing information about value-based, quality-focused immunization purchasing strategies.

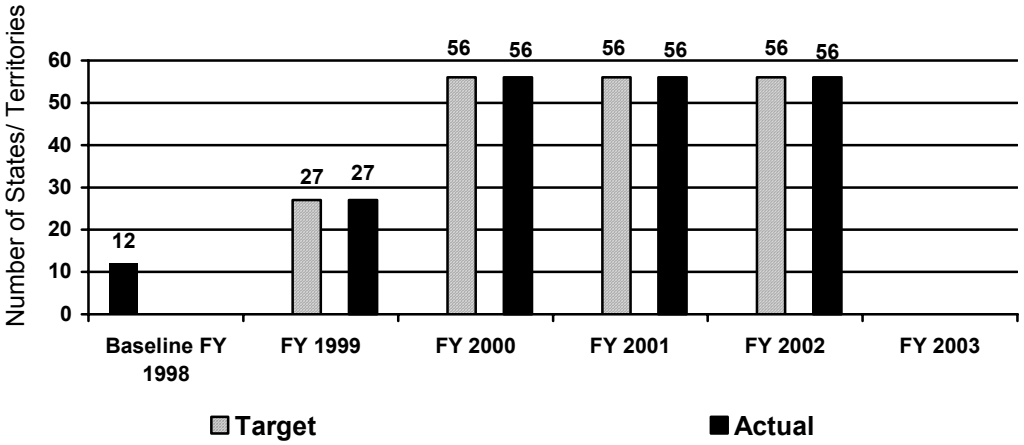
Data Source(s): Due to the various data collection and reporting methodologies likely to be used by individual States, immunization coverage levels will not be directly comparable across States. However, each State will measure its own progress, using a consistent measurement methodology.

The Health Plan Employer Data Information Set (HEDIS®), the Clinical Assessment and Software Application (CASA), and immunization registries provide standardized measurement of childhood immunization. HEDIS provides a plan-based measure of the care delivered to enrollees; it is the national standard in performance measurement for managed care organizations (MCOs). The HEDIS® Childhood Immunization Measure estimates the percentage of children in an MCO who received all of the appropriate immunizations by their second birthday. CASA is a public domain tool that was developed by the CDC for measuring immunization performance at the provider or clinic level.

Verification and Validation: The means for verifying and validating immunization data will vary from State to State, depending on the State-specific data collection methodology. A key part of the technical assistance provided by CMS and the CDC will include helping States address data reliability.

Performance Goal MMA3-02

Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries
(*Discontinued after FY 2002*)



Discussion: Individuals who are dually eligible for Medicare and Medicaid are an important and growing population. In 2002, there were approximately seven million individuals dually eligible for Medicare and Medicaid at some point in the year. Although dually eligible beneficiaries represent about 17 percent of the Medicare population, they represent 30 percent of total Medicare expenditures. Similarly, while dual eligibles represent approximately 17 percent of the Medicaid population, they represent about 35 percent of total Medicaid expenditures.

Through continued innovation and reform in the Medicare and Medicaid programs, CMS hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries. In order to do this, State Medicaid program administrators need information on their dually eligible populations.

States, as well as providers of care, are increasingly interested in assessing how well our programs respond to the needs of dually entitled beneficiaries. The CMS's development of a tool for matching State finder files against Medicare enrollment files will be of assistance to States to improve the efficiency and effectiveness of the acute and long-term care services received by persons eligible for both Medicare and Medicaid. States will be able to use data from the Medicare linked files to perform analyses that can improve the understanding of the program interactions between Medicare and Medicaid and how the interactions affect access to care, costs, and quality of services. For example, the dual eligible Medicaid/Medicare data will strengthen the ability of CMS and States to develop efficient and effective risk-adjusted payment methods for dual eligibles.

Coordination: The Department of Health and Human Services and CMS have worked together to develop CMS systems tools that will support matching of State finder files against Medicare enrollment and Group Health data, and provide that matched data back

to States in a standard format. This effort has included collaboration with States to establish useful access to Medicare operational data.

Data Source(s): The joint Federal and State interest in dual eligibles has resulted in an examination of the data that are available to obtain knowledge about the demographic characteristics, health status, disease episodes, support services, health services utilization, and expenditures of this diverse population. The best and most current source for Medicare enrollment and Group Health data is the Medicare enrollment database (EDB). By matching current EDB data against State-submitted Medicaid finder files, CMS can provide States with accurate data identifying dual eligibles in their Medicaid populations. Based on these data, States can perform valuable analyses of their dual eligible populations. States can also then develop target populations for which they can request Medicare billing data. This combination of enrollment and Medicare billing data provides the States a powerful analytic base against which they can evaluate many aspects of dual eligibility.

Verification and Validation: All of the systems serving as sources are crucial operational systems that have built in quality assurance checks.

Performance Goal MMA4-04

Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates

Baseline: Prior to FY 2001**,** Illinois, Texas, and Kansas have independently developed methodologies to conduct State level Medicaid payment accuracy studies; no suitable methodology to produce national level estimates has been developed.
FY 2004 Target: Pilot test the CMS PAM Model in up to twenty-five States and develop the final specifications for the model; this model is expected to produce both State specific and national level estimates. This model was developed as a result of FY 2002 experiences and initially pilot tested with twelve States during FY 2003.
FY 2003 Target: Expand the PAM Program to twelve States. Pilot test the CMS PAM Model in all twelve of these States. Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to develop draft final specifications for the CMS PAM Model.
FY 2002 Target: Nine pilot States will conduct payment accuracy measurement studies. The CMS and The Lewin Group (contractor) will work with the pilot States, and assess Medicare and other Medicaid payment accuracy measurement experience to define several promising methodologies for testing in FY 2003 and 2004. Contingent upon the availability of special grant funds, we will solicit participation by up to 15 States in Year 2 of the pilot (FY 2003). **Performance:** Goal met. Nine States have developed payment accuracy methodologies as part of their participation in the pilot study; final reports will be reviewed as part of the FY 2003 Target.
FY 2001 Target: Establish the feasibility of conducting pilot projects within States. We will work with two States to conduct payment accuracy studies. The preliminary data gathered from these two States would be used to help refine payment accuracy methodologies and assess the feasibility of constructing a single methodology that could be used by all States. **Performance:** Goal not met. Delays in receipt of funding to support State pilot studies and outside consultant assistance, and in soliciting State participation in the pilot, resulted in our not approving until late September 2001 the outside contractor and the initial group of pilot States.

Discussion: The CMS is committed to assisting interested States in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates. The purpose of this goal is to explore the utility and feasibility of conducting Medicaid payment accuracy studies in all States using a single methodology. No accepted methodology for Medicaid payment accuracy measurement (PAM) currently exists, and only a handful of States have done any work in this area. Those that have done so have all used different approaches, and none have addressed PAM in a managed care environment.

During FY 2000, CMS, together with the American Public Human Services Association, established a National Medicaid Payment Accuracy Workgroup to help define, guide and coordinate this Federal-State collaborative project. Information was collected on the significant Medicaid payment accuracy studies conducted to date (by Illinois, Texas and Kansas), and discussions were initiated with several States that might be interested in participating in the pilot studies.

Resource constraints have proved a major obstacle to States conducting Medicaid payment accuracy studies. In order to support States in these activities, in FY 2001 and FY 2002, CMS requested funding from the "wedge" portion of the Health Care Fraud and Abuse Control (HCFAC) account; $2,552,000 was approved.

This program funding was used to retain a consultant to work on the project and to subsidize State participation in the first year of the demonstration project. The consulting contract was awarded in September 2001 to The Lewin Group. A letter requesting proposals was sent to all State Medicaid and Program Integrity Directors on July 3, 2001. The CMS approved funding for all nine States that applied: Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington and Wyoming. The approved first-year budgets for the States total $3.6 million. The pilots will be 100 percent federally funded, with the participating States being reimbursed roughly $1.8 million of their costs through regular Medicaid funds and roughly $1.8 million from the HCFAC grant funds. The participating States will test various approaches to Medicaid PAM and work with CMS and The Lewin Group to maximize the collective learning.

The CMS anticipates expanding the pilot study to twelve States in the second year. FY 2002 HCFAC funds totaling $2,675,000 have been approved to subsidize this project during FY 2003. As in the first year, the HCFAC funding will be used to retain our consultant contractor and partially subsidize State participation. Our goal is to further develop, refine, and pilot test the CMS PAM Model that can be used to produce State-specific and national Medicaid payment accuracy rates. During the second year of the project, we intend to pilot test the CMS PAM Model in all twelve States. The CMS and The Lewin Group will also develop draft final specifications for the CMS PAM Model to be pilot tested in up to twenty-five States in FY 2004.

Coordination: Coordination within CMS will occur to ensure that our relevant Medicare, Medicaid and program integrity staff work together and with the Office of Inspector General. The CMS will work closely with the pilot States, as well as with States collectively through the National Association of State Medicaid Directors. During the second year, The Lewin Group will be providing technical assistance to all twelve States pilot testing the CMS PAM Model.

Data Source(s): The nine pilot States in the first year used their own Medicaid paid claims, encounter data, and related medical records, and tested differing PAM methodologies. During the second year, all twelve States will continue to use their own paid claims and medical records, however, all twelve states will be pilot testing the CMS PAM Model.

Verification and Validation: The CMS and The Lewin Group will work with the pilot States, Medicare and the Inspector General to evaluate the various PAM methodologies, including the data sources and validation techniques. During the second year, CMS and The Lewin Group will work closely with all twelve States pilot testing the CMS PAM Model to ensure that implementation is consistent across the participating States.

Performance Goal MMA5-04

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP)

Baseline: Developmental.
FY 2004 Target: **-- Medicaid** **(a)** Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States. **-- SCHIP** **(a)** Refine data submission, methodological processes, and reporting; **(b)** Produce 2002 performance measures in standardized reporting format (testing phase); and **(c)** Collect 2003 data (baseline) from States.
FY 2003 Target: To begin working with States on the Performance Measurement Partnership Project (PMPP). **-- Medicaid** **(a)** Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and **(c)** Initiate action steps for implementing recommendations. **-- SCHIP** **(a)** Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b)** Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; **(c)** Initiate action steps for implementing recommendations; and **(d)** Begin to implement core SCHIP performance measures.

Discussion: The use of performance measures to improve health care quality is widespread in the public and private sectors. However, its use in the Medicaid program has been primarily undertaken by State Medicaid agencies. At the national level, we are only beginning to collect and analyze information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. Since we are still far from having a complete picture of the quality of care that the Medicaid population receives on a national basis, the Medicaid program's ability to fully respond to and take advantage of the Government Performance and Results Act (GPRA) in a manner that best achieves the stated purposes of the Act is not yet realized.

The CMS took a first step in 1999 to improve health care quality for a high priority population of Medicaid beneficiaries--children--with its GPRA goal to improve childhood immunization (MMA2-04).

The following evidence supports the position that the use of performance measurement can improve service delivery to those individuals it is intended to serve:

- knowledge and experience we gained from the childhood immunization project;
- expanding use of performance measures in the health care industry;

- increasing experience of States in using performance measures in Medicaid programs, and
- provisions of the Balanced Budget Act of 1997 requiring the use of performance measures for the SCHIP program

Because of the Federal-State partnership in the Medicaid and SCHIP programs, improvements in the use of performance measures would be best accomplished if jointly identified by both CMS and States.

In FY 2002, CMS began working with States to jointly explore a strategy for State and Federal use of performance measures. CMS asked States to help chart a course of action that would effectively use reliable and valid performance measures to quantify and stimulate measurable improvement in the delivery of quality health care. The Performance Measurement Partnership Project (PMPP) is Medicaid's first effort to develop performance measures based on consensus and voluntary State participation. As part of this effort, seven HEDIS® measures were proposed by a workgroup of State Medicaid and SCHIP officials as performance indicators that States would report annually on a voluntary basis.

The purpose of this goal is to utilize the information gathered from States to establish formal collaborations that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures.

By the end of FY 2003, CMS and States will have agreed on a strategy for the coordinated use of performance measures within and across Medicaid and SCHIP programs for quality improvement in both fee-for-service and managed care delivery systems. Our communications with States to-date indicate that they will be supportive of this position. As CMS and States proceed to implement this mutually-agreed upon strategy, we will identify multiple approaches to using performance measures to achieve improvements in health care quality

It will take time and additional work to develop specifications for reporting the performance measures for FFS delivery systems. States will report their values (on a voluntary basis) for the seven HEDIS® measures to CMS until such time as a unified data system can be used to calculate measures on behalf of States. SCHIP performance measures will be collected through the SCHIP annual report framework each year.

Coordination: CMS will work with State Medicaid and SCHIP programs to develop a strategy for performance measurement to improve health care delivery and quality for Medicaid and SCHIP populations.

Data Source(s): Developmental. Once CMS and the States have identified the strategy for appropriate use of performance measurement, we will develop data sources to measure accomplishment of this strategy.

Verification and Validation: Developmental.

State Children's Health Insurance Program

State Children's Health Insurance Program	FY 2001 Enacted	FY 2002 Enacted	FY 2003 Current Law	FY 2004 Current Law
Budget Authority	**$4.2 B**	**$3.1 B**	**$3.2 B**	**$3.2 B**
Redistribution Funding	**$2.0 B**	**$2.8 B**	**$2.2 B**	**TBD**
Total Budget Authority	**$6.2 B**	**$5.9 B**	**$5.4 B**	**$3.2 B**

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP). This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. The statute authorizes and appropriates an annual amount that CMS grants to States and Territories with an approved SCHIP plan. States were given the option to expand their Medicaid program, establish a separate SCHIP program or a combination of both. Currently, all States and Territories have approved SCHIP plans. Many States are submitting plan amendments and section 1115 waivers to further expand insurance coverage under SCHIP.

Another representative goal related to this budget category but not listed in the chart below is:

- Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) (MMA5-04)

Performance Goal	Targets	Actual Performance	Ref.
Decrease the number of uninsured children by working with States to implement SCHIP and by enrolling children in Medicaid -- Increase the number of children enrolled in regular Medicaid or SCHIP	**FY 04:** + 5% over 2003 **FY 03:** + 5% over 2002 **FY 02:** + 1,000,000 over 2001 **FY 01:** + 1,000,000 over 2000 **FY 00:** + 1,000,000 over 1999 **FY 99:** Develop goal; set baseline and targets	**FY 04:** Expected late 12/04 **FY 03:** Expected late 12/03 **FY 02:** Additional 1,200,000 children enrolled in SCHIP and Medicaid (Goal met) **FY 01:** Additional 3,441,000 children enrolled in SCHIP and Medicaid (Goal met) **FY 00:** Additional 1,679,000 children enrolled in SCHIP and Medicaid (Goal met) **FY 99:** Baselines and targets set (Goal met); 21,980,000 **FY 98:** 21,180,000 **FY 97:** 21,000,000 in Medicaid, none in SCHIP **(Baseline)**	SCHIP1 See FY 03 Revised Final **3**

Performance Results Discussion

Decrease Uninsured Children - The implementation of SCHIP has stimulated enormous change in the availability of health care coverage for children and in the way government-sponsored health care is delivered. The energy invested by States and Territories, communities, and the Federal Government has resulted in significant expansions in coverage, as well as new systems for enrolling children. The CMS and the States exceeded our FY 2002 goal to enroll an additional 1,000,000 children in SCHIP or Medicaid over the previous year's level. In fact, due to the overwhelming success of the program, we enrolled 1,200,000 children over FY 2001's level.

When The State Children's Health Insurance Program began in 1997, CMS implemented an enrollment goal to enroll five million children in the program by FY 2005. Because we have exceeded this goal and are now seeing States face fiscal challenges that may affect program outreach and enrollment, we are unsure about future projections and have decided to set our FYs 2003 and 2004 targets to increase enrollment by five percent over the previous year.

Performance Goal SCHIP1-04

Decrease the Number of Uninsured Children[1] by Working with States to Implement SCHIP and by Enrolling Children in Medicaid

Baseline: In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid, and none in SCHIP.
FY 2004 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 5% over the previous year.
FY 2003 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 5% over the previous year.
FY 2002 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. **Performance:** Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 1,200,000 from the previous year.
FY 2001 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. **Performance:** Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 3,441,000 from the previous year.
FY 2000 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. **Performance:** Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 1,679,000 from the previous year.
FY 1999 Target: Develop a goal; set baseline and targets. **Performance:** Goal met.

Discussion: Enacted through the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP), under Title XXI of the Social Security Act, allocates nearly $40 billion over 10 years to extend health care coverage to low-income, uninsured children. SCHIP enables States to establish separate SCHIP programs, expand existing Medicaid programs, or use a combination of both approaches. Although estimates of insurance coverage for children vary, the Bureau of Census' annual March health insurance supplement to the Current Population Survey (CPS) is the most widely cited source. The CPS data for 1999 suggested that there were approximately 10 million children under the age of 19 who lacked health insurance coverage. Approximately one-third of uninsured children are eligible for Medicaid and are not enrolled in the program.

The implementation of SCHIP has stimulated enormous change in the availability of health care coverage for children and in the way government-sponsored health care is viewed and delivered. The energy invested by States, communities, and the Federal

[1] Children = up to age 19 for SCHIP and up to age 21 for Medicaid.

Government in the SCHIP program has resulted in significant expansions in coverage as well as new systems for enrolling children into publicly funded coverage programs. In many States, mail-in applications for children are used in separate SCHIP-funded child health programs and in Medicaid, and paperwork requirements imposed on families applying for coverage have been reduced significantly. According to the Statistical Enrollment Data System (SEDS), approximately 5.3 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2002, and many more were enrolled in "regular" Title XIX Medicaid through increased outreach efforts and application simplification strategies undertaken as a result of SCHIP.

When CMS conducted on-site reviews of States' Temporary Assistance for Needy Families (TANF) and Medicaid application and enrollment procedures in 1999, we found that the degree of investment States make to redesign their strategies--both to adapt to changes in law and to address longstanding barriers--profoundly affect whether or not eligible children and families receive Medicaid. Enrollment simplification, outreach, and changing the attitude toward government-sponsored health care can make a difference. Many States have simplified the application process for children, and CMS is encouraging States to make further improvements. However, many States have not made efforts to streamline and simplify practices for low-income families to the extent that they have for children; these Medicaid application procedures for families often remain tied to welfare program procedures. This has meant that the poorest children and their families often experience more barriers to coverage.

Despite many successes prompted by SCHIP, many children and families eligible for SCHIP and Medicaid have not been enrolled. Recent studies reveal that key remaining barriers include: 1) burdensome application or eligibility determination processes, 2) lack of awareness about the programs, 3) assumptions on the part of families that they are not eligible for the programs, and 4) the lingering stigma attached to government-sponsored assistance.

The best available data show 21 million children ever enrolled in Title XIX Medicaid during FY 1997 (before the inception of SCHIP***).***

Year	**Children Served by SCHIP (Title XXI)**	**Children Served by Medicaid (Title XIX)**	**Total Number of Children Served by SCHIP & Medicaid**	**Yearly Increase in Number of Children Served by SCHIP & Medicaid**	**GPRA Target** *(yearly increase in number of children served)*
1997	0	21,019,000 [2]	21,019,000	---	
1998	980,000	*20,200,000*	*21,180,000*	*161,000*	

[2] Ku, Leighton and Brian Bruen, "The Continuing Decline in Medicaid Coverage," December 1999. Available on The Urban Institute website at http://newfederalism.urban.org/html/anf_a37.html.

Year	Children Served by SCHIP (Title XXI)	Children Served by Medicaid (Title XIX)	Total Number of Children Served by SCHIP & Medicaid	Yearly Increase in Number of Children Served by SCHIP & Medicaid	GPRA Target *(yearly increase in number of children served)*
1999	1,980,000	*20,000,000*	*21,980,000*	*800,000*	
2000	3,334,000	*20,325,000*	*23,659,000*	*1,679,000*	1,000,000
2001	4,600,000	*22,500,000*	*27,100,000*	*3,441,000*	1,000,000
2002	5,300,000	*23,000,000*	*28,300,000*	*1,200,000*	1,000,000
2003	--	--	--	--	5%
2004	--	--	--	--	5%

Note: Italicized figures are estimates based on incomplete Title XIX data submitted by the States. These estimates will be updated as edited HCFA-2082 data become available.

Coordination: To assure that both Medicaid and SCHIP fulfill their potential, CMS is working with States, various operating divisions within HHS, other Federal Government agencies, and the private sector on a broad array of outreach activities. These activities include providing technical assistance to States, providing new resources to States to help them improve their programs, working with other Federal agencies; and promoting the exchange of information among States, community-based organizations, advocacy groups, Government grantees, and private sector groups -- just to mention a few.

For example, CMS has contracted with Maximus to develop model applications for the Medicaid and SCHIP programs. The applications will be designed to target the appropriate reading levels of potential enrollees and will be available in both English and Spanish. Additionally, Maximus will develop model notices that are most frequently sent to Medicaid and SCHIP enrollees for States to adopt into their programs. These efforts serve not only to improve the readability of applications and notices but also to provide a better understanding of how to enroll and access services under Medicaid and SCHIP. Related efforts include convening regional conferences and the National Summit on School-Based Outreach for SCHIPs; identifying successful school-based outreach and enrollment strategies for SCHIP and Medicaid; and collaborating with the American Public Human Services Association to exchange best practices among States.

Data Source(s): States are required to submit quarterly and annual State Children's Health Insurance Program statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS) (formerly known as Statistical Information Management System). Using these forms, States annually report unduplicated counts of the number of children under age 19 who are enrolled in separate SCHIP programs, Medicaid expansion SCHIP programs, and regular Medicaid programs. The SCHIP enrollment counts presented in this update are the sum of the unduplicated number of children ever enrolled in separate SCHIP programs during the year and the unduplicated

number of children ever enrolled in Medicaid expansion SCHIP programs during the year.

The estimate of 21,000,000 for Medicaid enrollment for FY 1997 is based on HCFA-2082 data edited by The Urban Institute and published in December 1999. Although we previously reported a 1997 baseline of 22,700,000 children enrolled in Medicaid, this was based on unedited HCFA-2082 data and incomplete data reported by the States through SEDS. The CMS and the States consider the 21,000,0000 Medicaid enrollment figure to be a final estimate for 1997. This figure is also cited in the first annual report of the CMS-funded evaluation of SCHIP by Mathematica Policy Research (posted on the web at http://cms.hhs.gov/schip/mpr12301.asp).

The 1998-2001 Medicaid enrollment counts presented are estimates based on interim data submitted by the States through SEDS and are therefore subject to change when edited HCFA-2082 data become available. In general, edited data for a fiscal year are available about two years after the end of the year.

States may eventually report all of their SCHIP and Medicaid data through the Medicaid Statistical Information System (MSIS). Reporting Medicaid data through MSIS is now required for all States; and we are working with States to help them use MSIS to streamline their Medicaid and SCHIP reporting and improve CMS's ability to analyze data across programs. However, there are significant time lags in collecting and editing these data through MSIS. Therefore, we will continue to rely on the States' quarterly and annual statistical report submissions through SEDS, with updates from edited HCFA-2082 data, as such data become available.

Verification and Validation: The program enrollment data that States submit through SEDS are reviewed by CMS personnel every quarter. These data also are subject to audit and are being reviewed and analyzed as part of a National Evaluation contract awarded to Mathematica Policy Research.

The CMS will measure, to the extent possible, the unduplicated count of the number of children who are enrolled in any of the following programs: regular Medicaid; expansions of Medicaid through SCHIP; and separate SCHIP programs as reported by the States. While we consider an unduplicated count to be an appropriate measure for this goal and we can measure the unduplicated count within each program, some children may be enrolled in Medicaid at one point in the year and in SCHIP at another point, making it difficult to establish an accurate unduplicated count across all programs. Similarly, the SCHIP counts include some double counting of children in States that have combination programs. To the extent our data allow, we will closely monitor this issue.

Clinical Laboratory Improvement Amendments (CLIA)

Clinical Laboratory Improvement Amendments	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Collections/ Budget Authority	**$40.8 M**	**$43.7 M**	**$43.0 M**	**$43.0 M**

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) strengthen quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens for health purposes. There are approximately 177,300 CLIA certified laboratories. Approximately 78 percent (138,565) of these laboratories perform test methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and, therefore, are not subject to proficiency testing (PT). Under CLIA, CMS will continue its partnership with the States to certify and inspect approximately 21,800 laboratories during the FY 2004 - 2005 survey cycle. This is the number of non-accredited laboratories to be surveyed every two years.

Performance Goal	Targets	Actual Performance	Ref.
Sustain improved laboratory testing accuracy			CLIA1
-- Percentage of laboratories enrolled in proficiency testing (PT) with no failures	**CY 04:** Goal Discontinued **CY 03:** 90% **CY 02:** 90% **CY 01:** 90% **CY 00:** 90% **CY 99:** 90%	**CY 04:** N/A **CY 03:** Expect data 3/04 **CY 02:** Expect data 3/03 **CY 01:** 92.5% (Goal met) **NEW DATA** **CY 00:** 91.9% (Goal met) **CY 99:** 91.3% (Goal met) **CY 98:** 88.1% **CY 97:** 88.6% **CY 96:** 87.4% **CY 95:** 69.4% **(Baseline)**	
-- Laboratories properly enrolled and participating in PT	**CY 04:** Goal Discontinued **CY 03:** 95% **CY 02:** 95% **CY 01:** 95% **CY 00:** 95% **CY 99:** 95%	**CY 04:** N/A **CY 03:** Expect data 3/04 **CY 02:** Expect data 3/03 **CY 01:** 96.4% (Goal met) **NEW DATA** **CY 00:** 96.4% (Goal met) **CY 99:** 95.4% (Goal met) **CY 98:** 94.8% **CY 97:** 94.4% **CY 96:** 93.2% **CY 95:** 89.6% **(Baseline)**	

Performance Goal	Targets	Actual Performance	Ref.
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver -- Increase the percentage of laboratories adhering to manufacturer's instructions	**FY 04:** TBD **FY 03:** New in FY 2004	**FY 04:** Expect data Spring 2005	CLIA2

Performance Results Discussion

Proficiency Testing -- Success in our PT program increases patient and physician confidence by producing a snapshot of a laboratory's ability to perform tests accurately. It also reduces the need for repetitive testing, which will reduce overall costs of medical care related to diagnostic testing. We exceeded our 2001 targets to sustain improved testing accuracy with 92.5 percent of laboratories having no failures and 96.4 percent of laboratories properly enrolled in PT. Interim data for our 2002 targets show that 92.7 percent of laboratories enrolled in PT with no failures and 97.1 percent of laboratories properly enrolled and participating in PT. Final data for our 2002 targets are expected in March 2003, and based on interim data we anticipate success.

The CMS feels that we have reached peak performance with the percentage of laboratories enrolled in PT with no failures and with the percentage of laboratories properly enrolled and participating in PT. We recognize that it is important to maintain these levels of laboratory testing accuracy and to continue to monitor performance in these target areas. However, we see a new opportunity to positively impact laboratory testing, by focusing on waived laboratory procedures (See CLIA2-04).

We will continue to report on our current PT goal through FY 2003, while gathering baseline data for our new goal. In FY 2004 we will report our new baseline and begin measuring improvement in the percentage of laboratories having/following manufacturer's instructions.

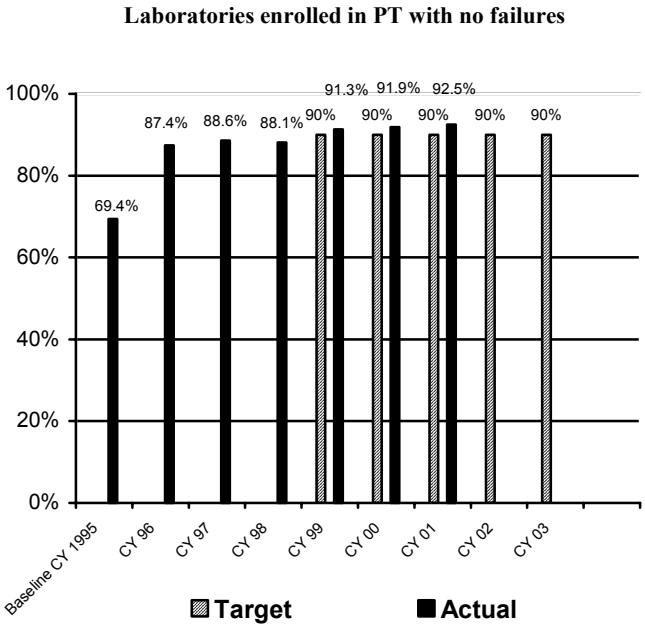
Waived Laboratory Testing -- Beginning in FY 2004, CMS is introducing a new goal to measure the percentage of laboratories performing waived tests (not subject to proficiency testing) that have/follow manufacturer's instructions. Currently, 78 percent of CLIA certified laboratories perform test methodologies that are so simple that the likelihood of erroneous results is negligible and, therefore, are not subject to PT.

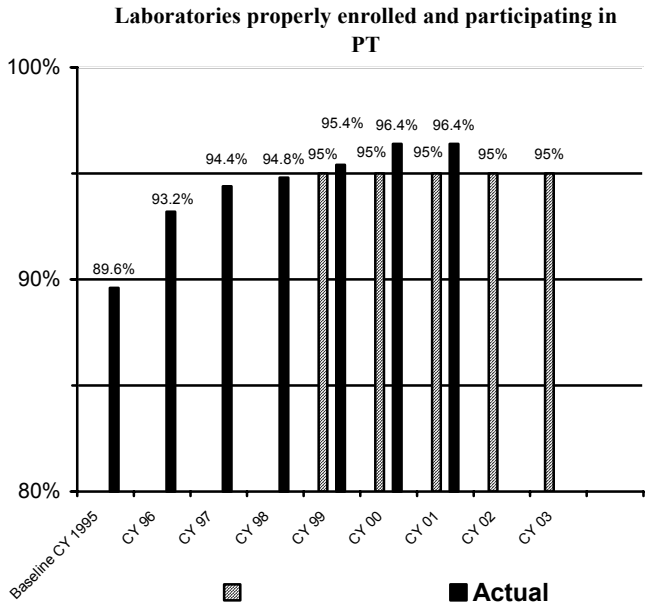
In FY 2002, an expanded pilot study of waived and provider-performed microscopy procedures laboratories in eight States demonstrated that 50 percent of laboratories performing waived tests did not have manufacturer's instructions or did not follow manufacturer's instructions (if they did have them). Based on data collected during revisits to waived laboratories that received education during and after the initial survey, awareness of and adherence to manufacturer's instructions improved considerably.

In FY 2003, CMS is conducting surveys on a nationwide sample to assess the number of laboratories performing waived tests that do not have manufacturer's instructions or do not follow manufacturer's instructions. A national baseline will be determined from this data, and in FY 2004, we will begin measuring improvement.

Performance Goal CLIA1-03

Sustain Improved Laboratory Testing Accuracy
(Discontinued after FY 2003)





Discussion: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. CLIA specifies quality standards for proficiency testing (PT), which provides CMS with a means of measuring laboratory performance. A laboratory's performance of PT provides CMS surveyors, CLIA surveyors, inspectors of approved accreditation organizations, and surveyors of approved State licensure programs with an excellent overview of the laboratory's current ability to produce accurate patient test results. Because of the continuous monitoring of PT by these individuals and the value of PT in general, we decided to use PT enrollment and successful PT performance as our target areas for improvement for this goal.

PT involves sending sample specimens with known properties to each laboratory three times per year, the results of which are not known to the laboratory. Laboratories' PT results are then evaluated for accuracy by CMS-approved private and State operated PT programs, following CLIA PT requirements. The PT testing is "blind," in that the laboratory staff members are not given any information about what they are expected to find. The CLIA regulation requires that the PT samples be tested in the same manner and by the same individuals as those performing patient testing.

Laboratory personnel, tests offered, and even laboratory size, location and environment are never constant. Because each can have a significant impact on test performance, we

decided to set our initial goals at the highest realistic levels possible, taking into consideration that many laboratories had never been regulated before CLIA. Setting high initial targets (what we believed to be a maximum expectation for 38,000 laboratories, with no assurance they could be met) gave us true goals to strive for in our ever-changing health care environment, and we believed anything less stringent would not have been acceptable, considering the clinical impact of laboratory results on the beneficiaries of Medicare and Medicaid, as well as all other patients.

PT increases patient and physician confidence in a particular laboratory by producing a snapshot of the laboratory's ability to perform tests accurately according to objective standards. This enhanced confidence in laboratory test accuracy reduces the need or inclination for repetitive laboratory testing and thereby reduces the overall costs of medical care related to diagnostic testing. Typically, a laboratory that performs well on PT also provides accurate testing results for clinicians, which aids in rapid and appropriate patient diagnoses and therefore contributes to effective treatment. There is a well-documented educational value for the laboratory from PT because of the opportunity and incentive for the laboratory to learn from its PT performance.

There are approximately 177,300 CLIA certified laboratories. Approximately 78 percent of these laboratories perform test methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and, therefore, are not subject to PT. (There are approximately two percent of laboratories that are CLIA-exempt; that is, they are located within States with CMS approved State licensure programs.) The remaining 22 percent of the laboratories must perform PT on the required tests or analytes and are overseen directly by CMS, the State survey agencies, or private accrediting organizations. There are currently 86 tests or analytes (i.e., cholesterol, glucose, white blood cell count, etc.) for which laboratories must perform PT under CLIA. This list of 86 analytes is largely made up of diagnostic tests, which are commonly performed and whose results are important to health care treatment decisions. Each laboratory performs PT on the required analytes that are a part of its specific test menu.

The CMS feels that we have reached peak performance with the percentage of laboratories enrolled in PT with no failures and with the percentage of laboratories properly enrolled and participating in PT. We feel that it is important to maintain these levels of laboratory testing accuracy and to continue to monitor performance in these target areas. However, we see a new opportunity to positively impact laboratory testing, by focusing on waived laboratory procedures (See CLIA2-04).

We will continue to report on our current PT goal through FY 2003, while gathering baseline data for our new goal. In FY 2004 we will report our new baseline and begin measuring improvement in the percentage of laboratories having/following manufacturers instructions.

Coordination: The CMS works closely with State surveyors, CMS-approved accreditation organizations, PT programs, CMS-approved State laboratory licensure

programs (CLIA-exempt laboratories) and professional advocacy groups in carrying out its CLIA activities.

Data Source(s): The primary data source is the Online Survey Certification and Reporting System (OSCAR). The PT enrollment rate is calculated using: (1) the number of laboratories in the OSCAR database that were subject to on-site survey and PT testing for at least one analyte, and (2) the number of laboratories cited as deficient for failing to be appropriately enrolled in PT. The rate at which enrolled labs perform successfully on PT is calculated using totals from the OSCAR database for: (1) the total number of tests performed for the year; and (2) the total number of failed scores received for the year.

Verification and Validation: Surveyors verify this data through ongoing monitoring of PT information, communicating with the laboratories and PT programs and by conducting biennial on-site surveys. The PT programs that provide the samples undergo an annual and ongoing review process coordinated by CMS with assistance from the Centers for Disease Control and Prevention. For example, the PT data system and PT programs are monitored to ensure that PT data transmitted to CMS is accurate, complete and timely.

Performance Goal CLIA2-04

Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver

Baseline: Developmental. In FY 2003, baseline data will be collected on a national scale for the number of laboratories holding a certificate of waiver that do not have manufacturer's instructions or do not follow manufacturer's instructions.
FY 2004 Target: To be determined. We will determine our FY 2004 target once we have reviewed baseline data.

Discussion: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988, establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. Certificates are issued to laboratories based on the complexity of testing that they perform. Laboratories are issued a certificate of waiver if they perform only waived tests. A waived test is defined as a simple laboratory test that has been determined by the Secretary of the Department of Health and Human Services to have an insignificant risk of erroneous results. Laboratories performing waived tests are required to follow manufacturer's instructions for performing the test, but they are not routinely surveyed.

In two independent studies, State surveyors in Colorado and Ohio found that about half of waived and provider-performed microscopy laboratories were out of compliance. Specifically, waived laboratories were not following manufacturer's instructions, did not have manufacturer's instructions onsite, or were conducting tests they were not authorized to perform. Those results were cited in a March 2001 report from the Office of the Inspector General (OIG) titled "Enrollment and Certification Processes in the Clinical Laboratory Improvement Amendments Program". These findings led to CMS initiating a pilot study in eight other states. The findings of the pilot mirror those of previous studies conducted by the states of Colorado, Ohio, and New York. The pilots demonstrated that 50 percent of laboratories performing waived tests did not have manufacturer's instructions or did not follow manufacturer's instructions (if they had them). If this percentage is nationally representative, as many as 60,000 laboratories may not be following manufacturers' testing instructions and may be performing tests incorrectly, with the potential result of patient harm.

Based on data collected in the above studies, during revisits to waived laboratories that received education during and after the initial survey, awareness of and adherence to manufacturer's instructions improved considerably.

In FY 2003, CMS is conducting surveys on a nationwide sample to assess the number of laboratories performing waived tests that do not have manufacturer's instructions or do not follow manufacturer's instructions. A national baseline will be determined from this data, and in FY 2004, we will begin measuring improvement.

Coordination: The CMS will work closely with State surveyors, the CDC, and CMS-approved accreditation organizations to further evaluate waived laboratories and to develop and implement strategies to improve the compliance of laboratories performing waived testing with the CLIA requirement of following manufacturer's instructions.

Data Source(s): The universe of laboratories to be surveyed is selected from the Online Survey Certification and Reporting System (OSCAR). The surveyors enter information collected during the surveys directly into the State Surveyors Information System (SSIS). The data in the SSIS is used to generate reports of findings for the analysis of laboratory compliance, trends and improvement. The SSIS will be the primary source for data in setting a baseline and reporting improvement. The data is collected during the survey via a standard questionnaire. The surveyor uses the answers on that questionnaire to input data into the SSIS.

Verification and Validation: Surveyors collect information on the questionnaire while on site and in contact with the laboratory. Surveyors enter the findings they have recorded into the SSIS so that national data can be gathered and analyzed. The SSIS system contains edits that prevent surveyors from entering data that is inappropriate or is inconsistent with other information on the questionnaire. A follow-up is done in 10 percent of the laboratories to validate the initial findings and improvements made by the laboratory as a result of the survey.

Medicare Integrity Program

Medicare Integrity Program	FY 2001 Actual	FY 2002 Actual	FY 2003 Current Estimate	FY 2004 Estimate
Total Budget Authority	**$680.0 M**	**$700.0 M**	**$720.0 M**	**$720.0 M**

The CMS's program integrity efforts ensure the Medicare program pays the right amount to a legitimate provider for covered, reasonable and necessary services that are provided to an eligible beneficiary. The CMS's program integrity activities are primarily funded through the Medicare Integrity Program (MIP), established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The MIP includes medical review and benefit integrity activities, provider education and training, Medicare Secondary Payer, and provider audits. The CMS's overall program integrity efforts are supplemented by funding from CMS's program management account and other funds made available from the Health Care Fraud and Abuse Control Account (HCFAC).

Another representative goal that are related to this budget category but is not listed in the chart includes:

- Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates (MMA4-04)

Performance Goals	Targets	Actual Performance	Ref.
Reduce the percentage of improper payments made under the Medicare fee-for-service program	**FY 04**: 4.8% **FY 03:** 5% **FY 02:** 5% **FY 01:** 6% **FY 00:** 7% **FY 99:** 9%	**FY 04:** **FY 03:** **FY 02:** 6.3% (Goal not met) **FY 01:** 6.3% (Goal not met) **(NEW DATA)** **FY 00:** 6.8% (Goal met) **FY 99:** 7.97% (Goal met) **FY 98:** 7.1% **FY 97:** 11% **FY 96:** 14% **(Baseline)**	MIP1 **3,8**
Develop and implement methods for measuring program integrity outcomes:			MIP2
-- Implement the Provider Compliance Rate prepay medical review	**FY 03:** Subsumed in MIP1 **FY 02:** Goal not continued. **FY 01:** Implement program	**FY 03:** **FY 02:** N/A **FY 01:** Implementation complete (Goal met)	
-- Implement the refined Comprehensive Error Rate Testing (CERT) program to produce subnational error rates	**FY 03:** Subsumed in MIP1 **FY 02:** Goal not continued. **FY 01:** Implement program	**FY 03:** **FY 02:** N/A **FY 01:** Implementation complete (Goal met)	
-- Develop a fraud rate among providers in a contractor's service area	**FY 03:** Subsumed in MIP1 **FY 02:** Implement program **FY 01:** Develop requirements	**FY 03:** **FY 02:** Progress dependent on HCFAC funding (Goal not met) **FY 01:** Progress dependent on HCFAC funding (Goal not met)	

Performance Goals	Targets	Actual Performance	Ref.
Improve the effectiveness of program integrity activities through successful implementation of the Comprehensive Plan for Program Integrity:			MIP3
-- Successfully implement the Comprehensive Plan	**FY 02:** Goal not continued **FY 01:** 100%	**FY 02:** N/A **FY 01**: (Goal met) **FY 00:** N/A **FY 99:** Plan initiated **(Baseline)**	
-- Measure effectiveness by achieving a significant portion of the performance measures for each of the ten Comprehensive Plan activities	**FY 02:** Goal not continued **FY 01:** Meet 90% of measures for each of the activities: 1a. Develop carrier/FI performance standards 1b. Implement PCR, CERT; and develop fraud rate 2. Implement program safeguard contractor (PSC) models 3a. Non-physician practitioner error rate 3b. Therapy services error rate 4. Improve the provider enrollment process 5. Assure Millennium contingency planning 6. Reduce the Inpatient hospital error rate 7. Data exchange to monitor care in congregate care settings 8. Implement managed care PSC and managed care payment validation 9. Community mental health centers error rate 10. Improve quality of care in nursing homes	**FY 02:** N/A **FY 01:** See status below 1a. Guidelines in use (Goal met) 1b. See goal MIP2 2. PSC operational models implemented (Goal met) 3a. Pending funds availability 3b. Available 02/2003 4. (Goal not met) 5. (Goal met) 6. 2.79 percent. (Goal not met.) 7. CMS contract with NHIC. Data available early FY 2003. 8. (Goal met) 9. Ten point plan implemented. Pending funds availability. 10. See goals QSC1 and QSC2 **(Baseline)** All new activities	

Performance Goals	Targets	Actual Performance	Ref.
Improve the Process of Credit Balance Recoveries	**FY 04:** Goal not continued **FY 03:** Fully implement revised processes and controls in contractor credit balance activities **FY 02:** Develop improved processes and controls to be utilized by contractors to ensure consistency and timely recoveries **FY 01:** Gather information on 1) provider credit balance identification, submission and resolution processes; and 2) contractor monitoring and resolution of credit balances	**FY 04:** Goal not continued **FY 03:** **FY 02:** Developed processes (Goal met) **FY 01:** See Final Review Summary Report and Final Management Overview Report (Goal met) **FY 00:** Incomplete information regarding credit balance reporting process **(Baseline)**	MIP5 See FY 03 Revised Final
Increase Medicare Secondary Payer liability and no-fault dollar recoveries **** Shaded area indicates version of the goal before the change in focus**	**FY 01:** Goal carried over with new focus (see above) **FY 00:** 5% increase over baseline	**FY 01:** N/A **FY 00:** 29.1% (Goal met**)** **FY 99:** 20% **FY 98:** $364 million **(Baseline)**	
Assess program integrity customer service	**FY 04:** Conduct survey and develop a corrective action plan (CAP) **FY 03:** Conduct survey and develop a CAP **FY 02:** Conduct and analyze surveys. Develop baseline and targets.	**FY 04:** **FY 03:** **FY 02:** Surveys are complete and a CAP has been developed (Goal met**)**	MIP6
Improve the provider enrollment process	**FY 04:** Continue to implement PECOS and revalidate 25% of Part A/Part B providers/suppliers **FY 03:** Implement PECOS, revalidate 20% of Part A providers **FY 02:** Develop PECOS, revise CMS-855, publish regulation	**FY 04:** **FY 03:** **FY 02:** PECOS implemented 7/29/02 (Goal met) Regulation and revised form are in clearance (Goal not met)	MIP7
Improve effectiveness of Medicare Secondary Payer (MSP) provisions by increasing number of voluntary data match agreements (VDMA) with insurers or employers	**FY 04:** 2 additional VDMAs	**FY 04:** **FY 03:** **FY 02**: 5 VDMAs (Baseline)	MIP8 **8**

Performance Goals	Targets	Actual Performance	Ref.
Reduce the Contractor Error Rate	**FY 04:** Develop baseline.	**FY 04:** **FY 03:** New in FY 04	MIP 9 **3,8**
Improve the Provider Compliance Rate	**FY 04:** Develop baseline.	**FY 04:** **FY 03:** New in FY 04	MIP 10 **3,8**
Decrease improper payment rate for home health services	**FY 01:** Goal not continued **FY 00:** 10% **FY 99:** 35%	**FY 01:** N/A **FY 00:** 29.5% **(NEW DATA)** (Goal not met) **FY 99:** 19% (Goal met) **1995-1996:** 40% **(Baseline)**	27-00

Performance Results Discussion

Medicare Error Rate - We have achieved extremely positive results in our effort to reduce improper payments. We have virtually cut the Medicare fee-for-service error rate in half over the past few years. Although we did not meet our target of a 5 percent error rate in FY 2002, we continue to claim success in maintaining the error rate at 6.3 percent. We believe there is still important work to be done and expect to achieve our goal of further reducing the error rate.

With implementation of the Comprehensive Plan for Program Integrity in FY 2001, CMS has focused its efforts on the Comprehensive Error Rate Testing (CERT) program. The purpose of CERT is to stratify the Medicare payment error rate to strengthen our ability to target problem areas.

The CERT program was fully implemented in 2002, therefore, CMS will produce a fee-for-service error rate for Durable Medical Equipment Regional Carriers (DMERCs) for FY 2002; for all Part B carriers for FY 2002; and for Part A contractors for FY 2003. To provide further quality assurance over the error rate estimate, CMS will produce the FY 2003 error rates with oversight provided by the OIG. For FY 2004 and beyond, CMS will assume the substantive testing portion of the CFO audit.

The Provider Compliance Rate (PCR) has also been implemented and will be produced as a product of CERT medical record reviews. In fact, in keeping with our commitment

to OMB during the Program Assessment Rating Tool (PART) process, CMS has developed two new FY 2004 goals measuring the provider compliance rate and the contractor error rate.

We did not meet our FY 2002 target to develop a model fraud rate program under CERT because we did not receive the HCFAC funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.

The Comprehensive Plan for Program Integrity – Through implementation of the Comprehensive Plan for Program Integrity, CMS has evaluated various initiatives in order to target high risk areas and better focus our resources to address problem areas. While we assessed our performance throughout the implementation process, it was also critical to monitor the overall effectiveness of each initiative in the plan throughout FY 2001. We continue to monitor many of these programs as we collect final data.

Program Integrity Customer Service – The goal to assess customer service behaviors in handling fraud and abuse cases would ultimately result in contractors developing a plan to assess customer service behaviors in the program integrity area. We have conducted surveys of beneficiaries and have analyzed the results. The CMS has formed a PI Customer Service Action Planning Team which has developed a nine point plan to improve program integrity customer service. Part of the plan includes training for contractors which was conducted during the summer of 2002.

Improve the Provider Enrollment Process - The goal to improve the provider enrollment process is an effort to continue the spirit of the Comprehensive Plan of paying claims properly to legitimate providers and suppliers. The CMS intends to have a streamlined and more uniform process for revalidating applications from providers of Medicare. To that end, CMS made the Provider Enrollment Chain Ownership System (PECOS) available to fiscal intermediaries on July 29, 2002. The fiscal intermediaries will begin to populate the system with data from new provider applications. We have not yet published the regulation pertaining to establishing and maintaining billing privileges, however, we expect to publish the regulation in early 2003. The revised CMS-855 form is pending the release of the regulation.

Medicare Secondary Payer/Credit Balance Recoveries - Medicare Secondary Payer (MSP) dollar recovery activities ensure that the appropriate primary payer makes payments for health care services for beneficiaries. The MSP activity attempts to collect timely and accurate information on the proper order of payers and to make sure that Medicare pays only for those claims where it has primary responsibility. In FY 2002, instead of focusing on no-fault dollar recoveries, we concentrated on the mandatory Medicare credit balance reporting requirements for providers. The intent of these requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. Approximately 90 percent of credit balances are mainly attributable to provider billing practices. The CMS met its FY 2002 target by developing improved processes for contractors to ensure consistency and timely recoveries of credit balances. These improved processes are

currently going through clearance prior to full implementation in FY 2003. We have also changed the name of the goal to "Improve the Process of Credit Balance Recoveries" to more accurately reflect the activity.

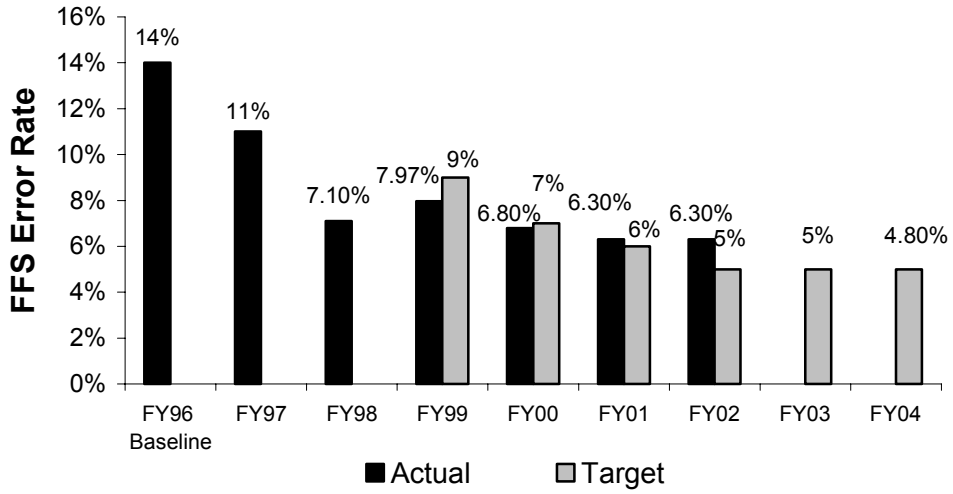
MSP Voluntary Data Match Agreements - We have introduced a new goal to further improve the effectiveness of the administration of the Medicare Secondary Payer provisions by increasing the number of Voluntary Data Match Agreements (VDMA) with insurers or employers. As we increase the number of VDMAs with large employers or insurers, we should be able to significantly decrease erroneous payments made by Medicare as the primary insurer when it should have been secondary.

Home Health Error Rate - Our efforts to reduce improper home health service payments paid off based on the repeat sampling of home health claims in California, Illinois, New York and Texas as part of an Office of Inspector General Operation Restore Trust study. This figure decreased from 40 percent in 1996 to 19 percent in 1999. In FY 2001, CMS replicated the OIG evaluation of home health claims using a sample of paid home health claims from January 1, 1999 to September 30, 1999 in the same four States, to determine if CMS's activities further reduced the rate of improper payment. Results indicate that the error rate was not reduced further; that in fact the error rate increased by approximately 10 percent resulting in a home health claims payment error rate of 29.5 percent. We believe that the increased error rate may be due to changes in provider behavior in anticipation of the implementation of the home health prospective payment system in October 2000.

This goal was discontinued in order for CMS to focus on other equally compelling fraud and abuse areas. However, in FY 2001 and following years, CMS will also continue to focus on reducing improper home health payments using a Program Safeguard Contract (PSC) Task Order to assess and recommend measures to improve the accuracy of the Outcome and Assessment Information Set (OASIS), the standardized assessment that is used to determine Medicare payment.

Performance Goal MIP1-04

Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program



Discussion: The purpose of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program. One of CMS's key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. The CMS has implemented a Corrective Action Plan (CAP) designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate. Examples of the positive effects of our corrective actions on reducing improper payments are illustrated in both the 1998 and 1999 Office of Inspector General (OIG) reports.

The CMS exceeded its GPRA targets for 1999 and 2000. In general, the substantial reduction in the error rate demonstrates that the Medicare contractor claims processing system is working well. Furthermore, during previous audits, a significant portion of improper payments reported were attributable to documentation errors. However, in FY 1998, documentation errors accounted for only $2.1 billion, a substantial decline from the $8.7 billion reported in FY 1996. The OIG attributed much of the substantial improvement in this category to the CMS CAP. The CMS agreed to continue these corrective actions in response to both the FY 1998 and 1999 audits.

In FY 2002, CMS did not reach the target of 5 percent, however we continued our success by maintaining the error rate at 6.3 percent. We will further reduce the error rate by continuing to focus our corrective actions on areas of vulnerability identified by the OIG. We believe that by aggressively addressing specific high risk areas we will continue to be successful in reducing the fee-for-service error rate.

The Comprehensive Error Rate Testing (CERT) program will be fully implemented in FY 2003; as such, the CERT program will produce a Medicare fee-for-service error rate for FY 2003. To provide further quality assurance over the error rate estimate, CMS originally intended to run the CERT program in parallel with the CFO Audit for at least one year; therefore, during FY 2003 both programs were to be used to produce national fee-for-service error rates. However, recent meetings with the Office of Inspector General (OIG) prompted an agreement that CMS will produce the FY 2003 error rate with oversight by the OIG. For FY 2004 and beyond, CMS will be assuming the substantive testing portion of the CFO audit.

In addition to the national error rate, CERT outcomes include contractor-specific error rates, as well as three additional rates used to help measure provider compliance with Medicare payment and billing requirements, and the accuracy of the contractor's claims payments and processing activities. These rates known respectively as the provider compliance rate, claims payment and claims processing rates, allow CMS to quickly identify emerging trends in managing Medicare contractor performance.

Coordination: We will continue to work with our partners in conducting our everyday business of ensuring Medicare claims are paid properly. We will build on the successes of Operation Restore Trust by continuing to work with the OIG, Department of Justice, and State survey agencies.

Data Source(s): The payment error rate has been computed by the OIG in fiscal years 1996 through 1999 as part of their Chief Financial Officer's Act audit. The CMS and OIG entered into an agreement stipulating that the OIG would act as CMS's agent to measure the Medicare fee-for-service error rate in FYs 2000 and 2001. The CMS will assume responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG.

Verification and Validation: The CMS will replicate OIG's methods as much as possible for FY 2002 to ensure consistent and equal comparisons across fiscal years. The CERT program was awarded to the Program Safeguard Contractor DynCorp in FY 2000. The CERT program is monitored for compliance by CMS through monthly reports from the contractor and a PSC evaluation team.

Performance Goal MIP2-03

Develop and Implement Methods for Measuring Program Integrity Outcomes
(Discontinued after FY 2003)

Baseline: The three proposed methods are new and currently in development and testing phases. Therefore, baseline data do not exist.
FY 2003 Target: Methods to be subsumed in MIP1-04.
FY 2002 Target: To implement a model fraud rate program. **Performance:** Goal not met.
FY 2001 Target: To implement the Provider Compliance Rate (PCR); the Comprehensive Error Rate Testing (CERT) program; and develop requirements for a model fraud rate program. **Performance:** Goal met (model fraud rate development dependent on HCFAC funding).

Discussion: The CMS is developing better methods to measure fraud, waste, and abuse in the Medicare program. This performance goal measures our progress in developing and implementing these methods.

The **Provider Compliance Rate (PCR)** is a method of determining a "compliance rate" among providers based upon a random sample of submitted claims. Essentially, the sampled claims are subjected to detailed medical review and a compliance rate is calculated based upon the dollar value ratio of valid claims to total claims. As such, the PCR provides a very useful measure of the appropriateness of claims submitted prior to payment. The PCR has been pilot tested over a two-year period at three contractor sites and is ready for full implementation. PCR was implemented during FY 2001 as part of the CERT program at all Medicare contractors. PCR is expected to both further enhance medical review effectiveness and promote provider compliance.

The Office of Inspector General (OIG) currently administers the CFO Audit, which provides CMS with a national fee-for-service claims payment error rate. However, the CFO audit does not provide a usable measure of improper payments at subnational levels. The CMS awarded a contract to implement the **Comprehensive Error Rate Testing (CERT)** program. CERT will produce contractor, provider and benefit specific error rates. These rates can also be aggregated to produce national level estimates similar to the CFO audit but with greater precision. The CERT program will provide substantially greater detail and analysis of vulnerabilities in the current system which will help focus corrective actions. The CERT program will be implemented in three phases. Phase 1 began in August 2000 at the four Durable Medical Equipment Regional Carriers (DMERCs). Phase 2 began at the carriers in April 2001. Phase 3 was implemented at the intermediaries in January 2002.

The CERT program will be fully implemented in FY 2003; as such, the CERT program will produce a Medicare fee-for-service error rate for FY 2003. To provide further quality assurance over the error rate estimate, CMS will produce the FY 2003 error rate with

oversight by the OIG. For FY 2004 and beyond, CMS will be assuming the substantive testing portion of the CFO audit.

The CMS tasked a Medicare contractor to develop and pilot test a method for estimating a **fraud rate** among providers in a contractor's service area. The pilot program includes drawing a random sample of claims using the CERT platform, contacting beneficiaries, and conducting interviews. The beneficiary interviews are considered critical in determining whether the provider actually delivered the stated services on the claim. However, due to the complexity of measuring fraud, numerous other indicators are required in order to produce a reliable estimate. We did not meet our FY 2002 target to develop a model fraud rate program under CERT because we did not receive the funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.

Coordination: We will continue to work with OIG, our PSC contractors, and our Medicare contractors to develop the projects identified in this goal.

Data Source(s): Monthly reports are received from the contractor to verify that they have complied with the phases proposed in the CERT implementation timetable for the Medicare contractors. The first CERT error rate and PCR reports for the four DMERCs were published in January 2002. These same reports were published for the carriers on the VMS system in April 2002 and in August 2002 for the carriers on the EDS MCS system. The first national error and PCR rates will be published for FY 2003.

Verification and Validation: The CMS verifies contractor performance and data through its Contractor Performance Evaluation program.

Performance Goal MIP3-01

Improve the Effectiveness of Program Integrity Activities through the Successful Implementation of the Comprehensive Plan for Program Integrity
(Discontinued after FY 2001)

This goal was designed to monitor the implementation and measure the effectiveness of CMS's Comprehensive Plan for Program Integrity. The Comprehensive Plan outlined CMS's overall program integrity strategy, as well as ten specific 6 to 18 month initiatives that were to improve the effectiveness of our program integrity efforts. Five of these initiatives addressed program management issues and the other five initiatives addressed specific benefit areas that we suspected were high program vulnerabilities.

PI Comprehensive Plan Performance Sub-goal	Target	Actual Performance
1(a). Increase the effectiveness of medical review and benefit integrity activities: Improve quality of medical review and benefit integrity outcomes	Develop and implement Medicare carrier and FI program integrity performance standards that measure quality and desired outcomes.	**Goal met**. Guidelines were tested in 1999, refined in 2000 and further streamlined for use in FY 2001
1(b). Increase the effectiveness of medical review and benefit integrity activities: Develop new methods to reduce the percentage of improper payments made under the Medicare fee-for-service program.	Implement the Provider Compliance Rate (PCR); implement the refined CFO audit methodology to produce a subnational error rate; implement a fraud rate program.	See goal MIP2-03.
2. Implement the Medicare Integrity Program	Implement four program safeguard contractor (PSC) operational models: functional, data analysis, benefit and full PSC.	**Goal met**. We have implemented the three PSC operational models and have awarded the contract for the fourth PSC model.
3(a). Implement Program Safeguards for BBA provisions: Establish (1) a national database of State statutes concerning non-physician practitioner licensure requirements, and (2) a process to measure the non-physician practitioner error rate.	Implement a national database of State licensure requirements for non-physician practitioners and to pay 90 percent of non-physician practitioner claims correctly.	The CMS has a database of State licensure requirements for non-physician practitioners and is in the process of making this information available to interested parties. **Implementation of a non-physician practitioner error rate is dependent on funds availability.**
3(b). Implement Program safeguards for BBA provisions: Create a therapy service program safeguards contractor (PSC)	Develop error rate for therapy services claims	DynCorp, the Comprehensive Error Rate Testing PSC, will produce an error rate for therapy services for years 1998, 1999, 2000. **These error rates may be available by February 2003.**
4. Promote Provider Integrity	Reduce the rate of return in the provider enrollment process by 30 percent.	**Goal not met.** Provider enrollment regulation not published. Goal continued in MIP7-04
5. Assure millennium contingency planning	Form contingency planning workgroups for Y2K	**Goal met.**
6. Inpatient hospital care	Reduce the payment error rate for inpatient hospital claims	**FY 2001: 2.79% Goal not met.** Baseline: 2.54% (1998)

PI Comprehensive Plan Performance Sub-goal	Target	Actual Performance
7. Congregate Care	Develop a data exchange analysis project with Medicare contractors and Medicaid State agencies to allow the coordinated monitoring of services provided to Medicare and Medicaid beneficiaries in congregate care settings	**CMS contract with NHIC, however, this part of the project is on hold pending funds availability.**
8. Managed Care	Implement the Enrollment Certification Contractor (ECC) and the Managed Care Program Safeguards Contractors (MCPSC)	**Goal met.** A PSC contract awarded to CMRI on 11/22/00 to perform managed care payment validation. A full and open competition was sponsored by CMS to create a schedule of Medicare Managed Care Program Integrity Contractors. Eight of these contracts were awarded earlier this year. ECC functions will be assumed by these new managed care contractors.
9. Community Mental Health Centers (CMHCs)	Reduce the payment error rate for CMHCs to 39 percent	10 point plan to address abuses implemented **. Pending funds availability, a PSC will reevaluate the error rate for FY 2001.**
10. Nursing Homes	Decrease the prevalence of pressure ulcers and restraints in nursing homes	See goals QSC1-04 and QSC2-04.

Performance Discussion

By developing and publicly distributing the Comprehensive Plan, CMS reinforced its commitment to fighting fraud and abuse in the Medicare and Medicaid programs. Promoting the integrity of Medicare and Medicaid is a top priority for CMS. As these programs have grown in size and complexity, so have the importance and challenges of that responsibility.

Achieving program integrity now requires the active involvement of every component of CMS, and effective coordination with our partners, including contractors, providers, beneficiaries, law enforcement, and others. Our overarching program integrity goal is straightforward. We strive in every case to pay the right amount, to a legitimate provider, for covered, reasonable, and necessary services, provided to an eligible beneficiary: to pay it right the first time.

In order to achieve this overarching goal, CMS's Comprehensive Plan addressed ten areas. Five of the initiatives in the Comprehensive Plan addressed program management vulnerabilities and the other five addressed specific service areas that we believed were vulnerable to fraud and abuse. The CMS began work on these initiatives in October 1999 and these initiatives were fully implemented in FY 2001. To assist us in evaluating the effectiveness of our efforts, we developed specific performance measures for each of the ten Comprehensive Plan initiatives.

Comprehensive Plan Sub-Goal Updates

(1) Increase the Effectiveness of Medical Review and Benefit Integrity Activities -- Plans for improvement in this area include increasing the overall level of medical review; hiring outside contractors to evaluate medical review practices and workloads across contractors; developing improved performance standards for contractor program integrity activities; and, conducting training for CMS and contractor staff to enhance the quality of fraud case referrals.

Goal (1a): Improve quality of medical review and benefit integrity outcomes.

Baseline: Current quantitative Medicare carrier and fiscal intermediary program integrity performance measurement process.

FY 2001 Target: To develop and fully implement Medicare carrier and fiscal intermediary program integrity performance standards that measure quality and desired outcomes.

Update Information: New Contractor Performance Evaluation (CPE) guidelines that focus on measuring quality outcomes have been developed and fully implemented. These guidelines were first tested during FY 1999. They were revised in FY 2000 and further streamlined for use in FY 2001. **Goal Met.**

Goal (1b): Develop new methods to reduce the percentage of improper payments made under the Medicare fee-for-service program.

Baseline: The three proposed methods described in the target are new.

FY 2001 Target: To implement the Provider Compliance Rate (PCR); to implement the refined CFO audit methodology to produce a subnational error rate; and to implement a fraud rate program.

Update Information: See goal MIP2-03 update.

(2) Implement the Medicare Integrity Program – The CMS is using its more flexible contracting authority to begin contracting with new entities called Program Safeguard Contractors (PSCs). The CMS has awarded 13 PSC contracts and between September and November of 1999 CMS awarded six program integrity task orders to these new contractors.

Goal: Implement a fully functioning Program Safeguard Contractor (PSC).

Baseline: Currently none of the three PSC modes are fully implemented. Additionally, there is no awarded contract for the full PSC model.

FY 2001 Target: To fully implement the following three PSC operational models: a functional model, data analysis model, and a benefit model. In addition, our goal is to award a PSC contract for the fourth PSC operational model, a full PSC model.

Update Information: We have implemented the three PSC operational models and have awarded the contract for the fourth PSC model. **Goal Met.**

Functional model:
Western Integrity Center: awarded to CSC 7/14/00 - fully operational
Benefit Integrity Support Center: awarded to EDS 11/24/99 - fully operational

Data Analysis Model:
Statistical Analysis Center: awarded to DYNCorp. 3/14/00 - fully operational

Benefit Model:
Therapy Service PSC: awarded to DYNCorp. 8/14/00 - fully operational

Full PSC Model:
DME PSC: awarded to TriCenturion 11/18/00 – fully operational 10/01

(3) Implement Program Safeguards for BBA Provisions -- The Balanced Budget Act of 1997 (BBA), created several new programs, benefits, and payment systems. Payment safeguards must be built into each of these prior to implementation. A variety of efforts are underway within CMS to prevent fraud in these new programs before it happens.

Goal (3a): Establish (1) a national database of State statutes concerning non-physician practitioner licensure requirements, and (2) a process to measure the non-physician practitioner error rate.

Baseline: Currently, there is no national database of State non-physician practitioner licensure requirements, nor is there a claims payment error rate for these services.

FY 2001 Target: Fully implement a national database of State licensure requirements for non-physician practitioners and to pay 90 percent of non-physician practitioner claims correctly.

Update Information: We have created a database of State licensure requirements. We plan to roll this information out to the Medicare carriers and fiscal intermediaries no later than September 2002. Additionally, pending funds availability, with the implementation of the Comprehensive Error Rate Testing program we will create a non-physician practitioner paid claims error rate. However, at this time, this project is on hold.

Goal (3b): Create a therapy service Program Safeguards Contractor (PSC).

Baseline: Currently, no therapy service PSCs exist, nor is there an established error rate for therapy service claims.

FY 2001 Target: To develop an error rate for therapy service claims.

Update Information: The Therapy PSC contract was awarded to DYNCorp on August 14, 2000. This contract will end in the fall of 2002, however the error rate task was transferred to the Comprehensive Error Rate Testing (CERT) PSC. The CERT PSC will produce the first therapy paid claims error rate for years 1998, 1999 and 2000 by February 2003. In future years, the error rate for therapy services will continue to be produced by the CERT PSC.

(4) Promote Provider Integrity -- Enrolling only high quality providers is key to assuring program integrity. Plans are underway to develop stricter standards and stronger conditions of participation, conduct on-site visits to verify legitimacy and compliance with standards, increase the frequency of re-enrollment, create a national provider enrollment database, establish surety bond requirements, collect Social Security numbers to improve accountability, and collect better ownership and financial solvency information.

Goal: Improve the provider enrollment process.

Baseline: 70 percent rate of return

FY 2001 Target: Reduce the rate of return by 30 percentage points to 40 percent.

Update Information: We will not meet this goal because we have not been able to take the steps necessary in FY 2001 to improve the enrollment process. First and foremost, while the provider enrollment form has been published in the Federal Register, the provider enrollment regulation has not yet been published. We are planning to implement the new form after final Federal Register publication of both the form and the regulation. Additionally, due to funding constraints, the Provider Enrollment Chain Ownership System (PECOS) is not yet implemented. This goal will continue as a stand alone goal for future years (See goal MIP7-04).

(5) Assure Millennium Contingency Planning -- With the advent of the new millennium, Medicare and Medicaid must continue to maintain fiscal integrity. We formed contingency planning workgroups and conducted extensive millennium related business analysis and risk analysis. We spent Summer 1999 testing our contingency plans. **Goal met.**

(6) Inpatient Hospital Care -- Inpatient hospital claims comprised at least 20 percent of the errors identified in the FY 1996, FY 1997, and FY 1998 CFO audits. These errors are particularly significant because they tend to be large claims. The CMS has developed a multi-faceted corrective action plan to reduce these errors, including the development of an inpatient claim Payment Error Prevention Program.

Goal: Reduce the payment error rate for inpatient hospital claims.

Baseline: 2.54 percent (FY 1998)
FY 2001 Target: 2.79 percent.
Update Information: The FY 1998 baseline has been established. The net payment error rate is approximately 2.54 percent. The FY 2000 net payment error rate is 2.56 percent. We will continue to monitor this error rate and develop corrective actions aimed at reducing the rate. **Goal not met.**

(7) Congregate Care -- Groups of beneficiaries gathered in one place, such as a skilled nursing facility, assisted living facility, or adult day care program, become easy targets for unscrupulous providers. Combating this type of fraud requires action on a range of fronts, and a series of proposals is being evaluated. These include assessments of CMS data and systems requirements necessary to understand these types of abuses, adjusting performance measures, and education efforts targeting congregate care facilities.

Goal: Develop a data exchange and analysis strategy to monitor the services provided to Medicare/Medicaid beneficiaries in congregate care settings.
Baseline: System does not currently exist.
FY 2001 Target: Develop and complete a data exchange analysis project with Medicare contractors and Medicaid State agencies to allow the coordinated monitoring of services provided to Medicare/Medicaid beneficiaries in congregate care settings.
Update Information: The CMS is contracting with National Heritage Insurance Corporation (NHIC) to conduct data matching and associated fraud and abuse review activities, utilizing data it presently warehouses from both Medicare and Medicaid programs operating in the State of California. The computer matching agreement has been approved, however, the congregate care project proposal is currently on hold pending funds availability.

(8) Managed Care – This initiative consists of three types of tasks: 1) implementation of Medicare+Choice (M+C) program integrity provisions as required under the Balanced Budget Act of 1997, 2) ongoing monitoring of M+C contractors, and 3) development of a Statement of Work (SOW) for one or more managed care program safeguard contractors (PSCs). The purpose of this goal is to fully implement two new types of contractors--the Enrollment Certification Contractor and the Managed Care PSC(s)--to assist us in accomplishing the three tasks defined in the Managed Care Program Integrity initiative.

Goal: Creating Additional Contractors for Managed Care.
Baseline: Currently there is no Enrollment Certification Contractor (ECC) and there are no Managed Care PSCs.
FY 2001 Target: Fully implement the Enrollment Certification Contractor and the Managed Care PSCs.

Update Information: On November 22, 2000 CMS awarded a contract to CMRI, a PSC contractor, to perform managed care payment validation work. Additionally, CMS met its goal and awarded contracts to eight Medicare Managed Care Program Integrity Contractors. There will not be a separate procurement for an Enrollment Certification Contractor. Instead, this work will be assumed by the Medicare Managed Care Program Integrity Contractors. **Goal met.**

(9) Community Mental Health Centers – The CMS plans a series of actions to strengthen oversight over this benefit. We have already begun a site-visit program to assess the compliance of CMHCs with Medicare rules, and plan to continue this effort. We will be issuing a clarification of the requirements applicable to CMHCs entering the program and subjecting new applicants to increased scrutiny, intensifying medical review for partial hospitalization claims, and increasing our audits of CMHC cost reports.

Goal: Reduce the payment error rate for Community Mental Health Center (CMHC) Partial hospitalization Claims.

Baseline: 90 percent error rate in 1996

FY 2001 Target: 39 percent error rate

Update Information: The CMS has fully implemented its 10-point plan to address the abuses identified in the CMHC setting. Based on the success of these efforts we expect to meet our error rate reduction target for FY 2001. Pending funding availability, a PSC will re-evaluate the CMHC error rate for FY 2001.

(10) Nursing Homes – The CMS plans several steps to improve the quality of care in the nursing home setting. We will impose sanctions more swiftly and increase the number of site inspections for repeat offenders, enhance Federal review and training for State inspection agencies, and continue building our national automated data system. Survey results will be posted on the Internet to increase accountability and flag problem providers for families and the public.

Goal: Decrease the prevalence of pressure ulcers in nursing homes. (For additional information, see goal QSC2-04).

Baseline: 9.8 percent

FY 2001 Target: 9.6 percent prevalence of pressure ulcers in nursing homes

Update Information: See QSC2-04.

Goal: Decrease the prevalence of restraints in nursing homes. (For additional information, see goal QSC1-04).

Baseline: 1996 - The mean prevalence of the use of physical restraints among all nursing homes in CY 1996 was 17.2 percent.

FY 2001 Target: Maintain a prevalence of the use of physical restraints at less than 10 percent.

Update Information: See QSC1-04.

Performance Goal MIP5-03

Improve the Process of Credit Balance Recoveries
(***Discontinued after FY 2003)***

Baseline: Incomplete information regarding credit balance-reporting process.
FY 2003 Target: To fully implement revised processes and controls in contractor credit balance activities.
FY 2002 Target: Develop improved processes and controls to be utilized by all contractors to ensure consistency and timely recoveries. **Performance:** Goal met. Developed improved processes. These processes are going through internal clearance prior to full implementation in FY 2003.
FY 2001 Target: Gather information on 1) provider credit balance identification, submission and resolution process; and 2) contractor monitoring and resolution of credit balances. **Performance:** Goal met. A Final Review Summary Report and a Final Summary Management Overview Report are now available.

Discussion: Studies performed by CMS and the Office of Inspector General (OIG) indicate that approximately 90 percent of credit balances are mainly attributable to provider billing practices. The intent of the mandatory Medicare credit balance reporting requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. Providers must: 1) maintain, during the admission process, a system that identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented; 2) bill other primary payers before billing Medicare except in certain liability situations; and 3) reimburse Medicare within 60 days if the provider receives payment for the same services from another payer. The HCFA-838 report must be completed quarterly by all hospitals and other health care facilities participating in the Medicare program to help ensure that monies owed to the Medicare program are repaid in a timely manner.

Providers who fail to follow these requirements risk losing participation in the Medicare program. Additionally, CMS instructions, in combination with regulations, furnish fiscal intermediaries (FIs) with the authority to sanction providers by suspending program payments if providers do not report credit balances on a quarterly basis. Medicare instructions require providers to follow specific procedures for credit balance reporting in order to guarantee recovery of any reported credit balances.

The CMS's initial review of the FI quarterly credit balance reports indicated that a high percentage of providers submit the HCFA-838 with a zero dollar credit balance. This is possible because the HCFA-838 provides a "snapshot" of the provider's credit balance activities rather than an ongoing view. However, CMS is vulnerable under this snapshot approach because it has no way to determine whether or not a zero balance on the HCFA-838 represents a very tightly run system or a provider that cleans up its credit balance accounts immediately before submitting the HCFA-838 each quarter (including situations where a provider zeroes out its credit balances, but does not make appropriate refunds to

the Medicare program). The CMS has identified instances where providers received two payments for the same service, but the provider reported a zero dollar credit balance during that period. Additionally, we identified providers that submitted the HCFA-838 timely and identified a credit balance, but did not submit adjustment requests or send in a check as repayment.

Providers that do not adhere to the reporting requirements of the credit balance report reduce potential savings to the Trust Funds. Due to limited resources and funding available to CMS, only a small percentage of providers can be audited each year. Credit balance reports may not be audited or reviewed for several years because they are only audited during onsite reviews.

Currently, CMS has no database with information specific to credit balance recoveries. This includes a lack of data on the timeframe within which reported credit balances are recovered through adjustment or payment by check.

Approaches include: 1) provider education (as well as attorney and insurer education); 2) instructions to the FIs to strengthen their analysis of the credit balance reporting overall and to specifically look at providers with a continuous zero dollar credit balance; 3) an increase in field audits with a strengthened review of credit balance reporting overall, including special emphasis on those providers with continuous zero dollar credit balance reporting; and 4) use of an independent contractor for data collection and analysis.

To reach our FY 2001 target, a consulting firm was used for data collection and analysis of 6 regional offices, 6 fiscal intermediaries and 24 providers. The methodology, observations, summaries and recommendations are now available in a Final Review Summary Report and a Final Summary Management Overview Report for use by CMS in the improvement of the credit balance recovery process.

To reach our FY 2002 target we revised instructions to both the contractor and the provider to ensure a clear understanding of each party's role and responsibility in the credit balance process. These revised instructions are under internal review. We plan to issue and implement them in FY 2003. Firms that specialize in identifying provider debts to third party payers have argued that providers frequently fail to identify and repay debts to Medicare. In order to gather evidence of this statement, CMS had executed task orders with two recovery contractors under contract with the General Services Administration (GSA) for government wide debt identification and collections activities. These recovery contractors were to audit selected hospitals to identify credit balances identified by the hospital but previously unreported to Medicare. The contractors were allowed to select a total of ten hospitals from a list supplied by CMS. One of the contractors asked to be released from the contract after auditing only three hospitals and finding no unreported credit balances. The other contractor did complete its audit of 10 hospitals and was able to identify some unreported credit balances. However, the number of unreported credit balances identified and the dollar amounts do not substantiate the need for further contracting of this function.

Coordination: The CMS, and the FIs will coordinate and monitor the efforts on this GPRA goal.

Data Source(s): Any increased recoveries will be reflected within financial statements as well as savings reports. A Final Review Summary Report and Final Summary Management Overview Report prepared by an independent contractor are now available. We will investigate the possibility of implementing tracking requirements specific to credit balance recoveries.

Verification and Validation: We rely on our contractors to report on their progress with credit balance activities. Their performance and data are evaluated through our Contractor Performance Evaluation Program.

Performance Goal MIP6-04

Assess Program Integrity Customer Service

Baseline: Program integrity customer service surveys are new; therefore baseline data do not exist.
FY 2004 Target: A survey of providers and beneficiaries will be conducted. Data from the survey will be used to identify weaknesses and develop a corrective action plan to deal with those weaknesses.
FY 2003 Target: A survey of providers and beneficiaries will be conducted. Data from the survey will be used to identify weaknesses and develop a corrective action plan to deal with those weaknesses.
FY 2002 Target: A survey of providers and beneficiaries will be conducted. Targets and a baseline will be developed from these data. **Performance:** Goal met. A corrective action plan has been developed.

Discussion: The CMS is developing a goal to measure and ultimately improve customer satisfaction with the manner in which our program integrity (PI) activities are conducted. This goal focuses on CMS's PI activities with respect to two distinct groups: the provider community and the beneficiary community.

The provider community interacts with CMS and its contractors in many ways. The enrollment process is viewed as burdensome by many providers due to the amount of information that must be supplied. Providers have voiced concern that they do not receive consistent feedback from CMS and its contractors regarding billing issues. They have expressed concern that simple billing errors can result in criminal findings. With respect to the provider community, the aim of this goal is to ensure that the subject of a PI-related review is satisfied with the manner in which their case was handled, even though they may not be satisfied with the outcome.

The CMS, in partnership with the American Association for Retired Persons (AARP), has encouraged beneficiaries to be aware of services billed on their behalf and to report any instances of suspected fraud. In many cases the beneficiary is reluctant to contact CMS or the contractor about a provider. They may fear retaliation or have loyalties, which create ambivalence. With respect to the beneficiary community, this goal will strive to ensure that their contacts are handled in a courteous, professional and attentive manner.

In pursuit of this goal, a contractor will coordinate focus groups, develop and perform surveys, and assist Medicare contractors in the development of customer service plans. The surveys will include, but not be limited to, provider enrollment activities, providers who have been the subject of medical reviews and cost report audits, and beneficiaries who have reported Medicare fraud complaints.

Once the survey and focus group data collection is complete, we will analyze the results and develop specific measures for this goal. The measures will quantify and track responses to survey questions and issues raised in focus groups. The results will help us determine the areas in which we should improve our service delivery.

Coordination: The CMS will work closely with its contractors and other stakeholders (e.g., AARP, American Medical Association, American Hospital Association) in carrying out this goal.

Data Source: Information collected from focus groups and surveys will be the primary data source for this goal.

Verification and Validation: The contractor carrying out the surveys and focus groups will be responsible for implementing quality assurance and standard protocols to ensure reliability of the data.

Performance Goal MIP7-04

Improve the Provider Enrollment Process

Baseline: Current data sources for information on the enrollment process are limited, which is why we are developing a national enrollment system.
FY 2004 Target: Continued implementation of PECOS and revalidating 25 percent of Part A and Part B providers/suppliers currently enrolled in the Medicare program using the new streamlined process.
FY 2003 Target: Implementation of PECOS and revalidating 20 percent of Part A providers currently enrolled in the Medicare program using a new streamlined process. This revalidation target will help capture those providers that entered Medicare using the CMS-855 enrollment form or that entered Medicare prior to the use of the CMS-855 enrollment form.
FY 2002 Target: Develop PECOS, implement the revised CMS-855 enrollment form and the regulation pertaining to establishing and maintaining billing privileges. **Performance:** PECOS was made available on July 29, 2002, for the fiscal intermediaries to begin populating the system with data from new applications (Goal met). The regulation is in the final stages of the clearance process and the revised CMS-855 forms are pending the release of the regulation. (Goal not met.)

Discussion: This goal is aimed at improving the certified provider enrollment process at the Medicare contractors. One of our key program integrity goals is to ensure we make payments to legitimate providers. This reduces the resources necessary to chase after improper payments. The goal of provider/supplier enrollment is to ensure that only qualified and legitimate individuals and entities receive the right to participate in the Medicare program.

By the end of FY 2002, we intend to have a streamlined and more uniform process of revalidating applications from certified providers for Medicare that will continue to promote the type of payment safeguards we implemented in 1996-1997 with the first nationally standardized enrollment application process.

With the implementation of the new CMS-855s, the Provider Enrollment Chain Ownership System (PECOS), and the "Enrollment Regulation," CMS and its contractors will have the ability to obtain a complete nationally formulated online standard history of any provider or supplier that has or had a business relationship with the Medicare program and the role or roles the individual or organization played in that relationship (e.g., physician, owner, manager, billing agent, etc.).

Coordination: The CMS will work closely with its Medicare payment contractors in carrying out the activities associated with this goal.

Data Source(s): Current data sources for information on the enrollment process are limited, which is why we are developing a national enrollment system. For this goal, we

will enter all provider/supplier enrollment data received via the revised CMS-855 Form (Provider/Supplier Enrollment Application) into PECOS. As all new enrollments are entered into PECOS, PECOS will track the workflow from data entry to final disposition. PECOS is expected to be implemented for the fiscal intermediaries by the close of FY 2002 and for the carriers by the second quarter FY 2003.

Verification and Validation: We use annual contractor performance evaluation protocol to assess Medicare contractor provider enrollment activities. PECOS data will be verified during annual, onsite surveys of contractors.

Performance Goal MIP8-04

Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Match Agreements with Insurers or Employers

Baseline: As of FY 2002, CMS has negotiated six (6) Voluntary Data Match Agreements (VDMAs) with employers and insurers
FY 2004 Target: Sign two (2) additional VDMAs.

Discussion: The purpose of this goal is to increase the number of VDMAs that CMS has with large employers and insurers for the purpose of exchanging employer or insurer health plan enrollment information for Medicare eligibility information. These data exchanges allow CMS to identify those Medicare beneficiaries who have group health coverage via their employment or via their spouse's employment. Medicare pays secondary in those situations where the beneficiary has group health plan coverage based on his/her own, or a family member's current employment. The VDMA allows CMS to receive this health plan coverage information from employers or insurers on a current (quarterly) basis, which enables Medicare to correctly process Medicare claims for primary or secondary payment. For employers, a VDMA can be used to satisfy their statutory obligation, under 42 U.S.C. § 1395y(b)(5)(c), to complete questionnaires resulting from the IRS/SSA/CMS Data Match process; and to provide that information to CMS on a more current basis.

Employers and insurers often do not know if their non-working enrollees under the age of 65 also have Medicare coverage, so they continue to make primary payments for individuals for whom Medicare is primary. The VDMA also allows employers and insurers to receive Medicare eligibility information for their insured who are not currently working. As part of the VDMA process, employers/insurers can send CMS basic identifying information on an individual they insure and CMS can identify those people entitled to Medicare including basic entitlement information such as periods of entitlement and the beneficiary's Health Insurance Claim Number.

The quarterly, mutual exchange of employee/insurer coverage information for Medicare eligibility information enables all parties to correctly process claims for primary and secondary payment. Additional benefits to CMS include: (1) a significant reduction in costs and administrative efforts associated with dispute resolution and recovery of mistaken primary payments, (2) lower long term operating costs for collection and storage of employer coverage data than via the IRS/SSA/CMS Data Match Project, (3) more accurate coverage data on a current basis and (4) increased customer service to beneficiaries and our Medicare partners.

Many of the advantages of VDMAs to CMS also apply to employers/insurers. An additional significant advantage for employers is that, if they sign a VDMA, they are excused from completing the annual IRS/SSA/CMS Data Match Questionnaire. Employers complain that the IRS/SSA/CMS Data Match can be costly, is difficult to plan

and budget for, and requires them to retrieve archived coverage information. Many employers have asked if there is a better way they could provide CMS with employee and spousal coverage information. The alternative is signing a VDMA. The CMS also benefits from having the employer submit employee coverage information via the VDMA. Rather than waiting the up to two and a half years it takes to identify potential working beneficiaries and their spouses via the IRS/SSA/CMS Data Match, CMS gets current coverage data every quarter directly from the employer/insurer. As previously stated, more timely coordination of benefits reduces expense and hassle to CMS, our partners and Medicare beneficiaries associated with CMS's attempts to recover mistaken Medicare primary payments by enabling Medicare to pay correctly the first time a claim is submitted for payment.

The CMS has made great strides to sign VDMAs with large employers/insurers. The resources required to electronically exchange information with CMS on a cost effective basis limit the potential market for VDMAs to very large employers and insurers. Currently, CMS has four signed employer VDMAs (AT&T, Lucent Technologies, General Electric, and Ford Motor Company), and is actively negotiating with several others. The CMS currently has one signed insurer voluntary agreement with Uniprise (United Health Care Insurance Company of New York – Empire Plan for Hospitals) and one agreement that has been signed by over forty private-side BCBSA Plans. With the recent signing of the BCBSA and Uniprise agreements covering such a large enrollee population, we anticipate CMS will sign additional insurer agreements. Inquiries have increased from other large insurers which represent significant sources of MSP information.

In addition to numerous print, mail and website promotions of VDMAs, CMS and the Coordination of Benefits (COB) Contractor have hosted or participated in numerous employer conferences and outreach programs. Due to these marketing efforts and word of mouth from current participants, requests for information about VDMAs has increased.

Coordination: The CMS will continue to work with its COB Contractor and other private and public partners to develop new ways of marketing VDMAs. The mutual benefits of these agreements help VDMAs to sell themselves to larger employers and insurers. However, given the size of the entities CMS seeks for this effort and the systems changes they must make to participate in this electronic data exchange, these agreements are usually protracted, with many internal and external variables affecting how many can be finalized in a given period. The CMS will continue to supervise the COB Contractor's promotion of VDMAs to employers/insurers as an alternative to the IRS/SSA/CMS Data Match and will monitor and actively support the efforts toward achieving this GPRA goal.

Data Source(s): The CMS receives the Medicare Secondary Payer (MSP) data from those entities, identified above, that currently have a VDMA with CMS. The employer/insurer sends its files to the COB Contractor for processing in the prescribed CMS format, and files containing information on covered working individuals are

transferred to CMS. The COB Contractor also processes the separate eligibility inquiry file sent by employers/insurers through the Enrollment Data Base to obtain the necessary Medicare entitlement information. The CMS does not use any of the data submitted in the employers eligibility inquiry file to update any of Medicare's records. Each file submission results in its own separate response file being sent back to the employer.

Verification and Validation: The COB Contractor edits and validates the data received by the employers/insurers through multiple independent processes before uploading any new MSP information to the Common Working File, a CMS database used in the claims adjudication process. All records with an error are identified and sent back to the employer/plan indicating why the record could not be processed. Records that do not contain errors are processed accordingly.

Performance Goal MIP9-04

Reduce the Medicare Contractor Error Rate

Baseline: Developmental.
FY 2004: Set Baseline

Discussion: The CMS implemented the Comprehensive Error Rate Testing (CERT) program in 2002 and is using the CERT methodology to develop the national fee-for-service error rate with greater precision than the previous OIG audit method. In addition, CERT will produce contractor, provider and benefit-specific error rates. The CERT program will provide substantially greater detail and analysis of vulnerabilities in the current system, which will help focus corrective actions.

CERT is a tool that CMS wants contractors to use to develop their medical review and provider education and training strategies. Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers. CERT will be used to establish the baseline error rates. Once a baseline is created, CMS will be able to track whether the corrective actions undertaken by the contractor are affecting their error rate. CERT is being used in the contractor performance based contracting pilots as a metric.

For each Medicare contractor, Medicare will conduct reviews for a statistically valid sample of claims and determine whether the contractor paid the claim accurately. The review will determine whether health care providers were underpaid or overpaid for the sampled claims. The results will reflect not only the contractor's performance, but also the billing practices of the health care providers in their region.

The results will lead to a contractor-specific error rate that Medicare will track to promote improvements. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claims review and other activities.

By FY 2008, CMS intends to have all Medicare claims processed by contractors that have an error rate of 5 percent or less. Critically important in reducing the contractor error rate is determining the root causes of error. Some errors may be caused by claims processing systems, unclear policies or CMS technical requirements. The CMS will use the information obtained through this process to revise policies and instructions, and institute systems changes, as well as use CERT as a measure of performance.

Our goal by FY 2008 is for all Medicare contractors to have an error rate of 5 percent or less. We are proposing the following annual targets:

FY 2005: 25 percent of Medicare claims will be processed by contractors who have a 5 percent or better error rate;

FY 2006: 50 percent of Medicare claims will be processed by contractors who have a 5 percent or better error rate;
FY 2007: 75 percent of Medicare claims will be processed by contractors who have a 5 percent or better error rate.

Once baseline data is received, CMS will evaluate these targets and modify as necessary to meet the primary goal.

Coordination: We will continue to work with OIG, our program safeguard contractors (PSC), and our Medicare contractors to develop the projects identified in this goal.

Data Source: Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers.

Verification and Validation: The CMS verifies contractor performance and data through its Contractor Performance Evaluation program. In addition, the OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

Performance Goal MIP10-04

Improve the Medicare Provider Compliance Rate

Baseline: Developmental
FY 2004: Set baseline.

Discussion: The Provider Compliance Rate (PCR) is a method of determining a "compliance rate" among providers based upon a random sample of submitted claims. The sampled claims are subjected to detailed medical review and a compliance rate is calculated based upon the dollar value ratio of valid claims submitted correctly to total claims. PCR was implemented during FY 2001 as part of the Comprehensive Error Rate Testing (CERT) program at all Medicare contractors. PCR is expected to further enhance medical review effectiveness and promote provider compliance.

CERT is a tool that CMS wants contractors to use to develop their medical review and provider education and training strategies. Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers. CERT will be used to establish the baseline provider compliance rates. Once a baseline is created CMS will be able to track whether or not the corrective actions undertaken by the contractor are affecting their provider compliance rate with providers.

Our goal by 2008 is to significantly improve the provider compliance rate. We are proposing the following annual targets:

2005: Increase the PCR 20 percent over the 2004 level.
2006: Increase the PCR 20 percent over the 2005 level.
2007: Increase the PCR 20 percent over the 2006 level.

Once baseline data is received, CMS will evaluate these targets and modify as necessary to meet the primary goal.

Coordination: We will continue to work with OIG, our PSC contractors, and our Medicare contractors to develop the projects identified in this goal.

Data Source: Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers.

Verification and Validation: The CMS verifies contractor performance and data through its Contractor Performance Evaluation program. In addition, the OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

Performance Goal 27-00

Reduce the Percentage of Medicare Home Health Services Provided for which Improper Payment is Made
(Discontinued after FY 2000)

Baseline: A 1997 report by the HHS Office of the Inspector General (OIG) on home health agencies revealed that, in four of the five States reviewed by the OIG as part of Operation Restore Trust (ORT), payments for 40 percent of Medicare home health services should not have been made. In generating this report, the OIG reviewed a sample of 1995 and 1996 paid claims data collected over a 15 month period which ended March 31, 1996.
FY 2000 Target: Reduce the home health error rate from 35 to 10 percent in California, Illinois, New York, and Texas by taking specific corrective actions, including implementing the home health provisions of the Balanced Budget Act of 1997. **Performance:** Goal not met.
FY 1999 Target: Reduce the home health error rate from 40 percent to 35 percent. **Performance:** Goal met.

Discussion: In 1997, the OIG of the Department of Health and Human Services (HHS) reported that nearly 40 percent of home health services provided in California, Illinois, New York, and Texas (which in 1995 represented nearly 28 percent of all nationwide home health agency reimbursements) did not meet the Medicare requirements for payment. Further, the report examined paid home health claims to determine whether services were delivered and if they met Medicare's criteria for payment. A random sample of claims during the 15-month period ending March 31, 1996 was reviewed, indicating specifically from on-site OIG staff reviews, that claims were improperly paid.

In FY 1999, the OIG repeated its evaluation of home health claims, using a sample of paid home health claims from January 1, 1998 to September 30, 1998 in the same four States, and determined that CMS's activities successfully reduced the home health claims payment error rate from 40 percent to 19 percent, exceeding the CMS goal of reducing the error rate in 1998 to 35 percent.

To accomplish this goal, CMS developed and implemented tools to fight fraud and abuse in the Medicare home health program that: strengthened the Agency's ability to identify problem home health agencies; prevented them from entering into the program; reduced losses to the Medicare program due to problem home health agencies; and, prevented inappropriate payments to providers by restructuring coverage and payment for home health services.

In FY 2001, CMS replicated the OIG evaluation of home health claims for a third and final time, using a sample of paid home health claims from January 1, 1999 to September 30, 1999 in the same four States, to determine if CMS's activities further reduced the rate of improper payment. Results indicate that the error rate was not reduced further; that in fact the error rate increased by approximately 10 percent resulting in a home health claims payment error rate of 29.5 percent. We believe that the increased

error rate may be due to changes in provider behavior in anticipation of the implementation of the home health prospective payment system in October 2000.

The CMS recognizes the importance of continued efforts to reduce improper home health payments. Our efforts include more effective provider education and payment monitoring activities. The CMS recently awarded a Program Safeguard Contract (PSC) Task Order to assess and recommend measures to improve the accuracy of the Outcome and Assessment Information Set (OASIS), the standardized assessment that is used to determine Medicare payment. Activities under this contract include national surveillance of home health data to identify provider educational needs and payment vulnerabilities. The CMS will continue to monitor the home health claims using the Comprehensive Error Rate Testing (CERT) PSC.

This goal was discontinued in order for CMS to focus on other equally compelling program integrity areas. In FY 2002 and following years, however, CMS will continue its efforts to reduce improper home health payments.

Coordination: Success at reducing home health fraud depends heavily on coordination both within and outside CMS.

Data Source(s): Independent audit of a statistical sample of paid claims was conducted by CMS or its agent.

Verification and Validation: The CMS contracted with an independent agent to evaluate the error rate of paid home health claims for the 9-month period from January 1, 1999 to September 30, 1999.

Medicare Operations

Medicare Operations	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	**$1,356.4 M**	**$1,532.0 M**	**$1,675.1 M**	**$1,776.9 M**

The Medicare Operations line item primarily funds the traditional Medicare fee-for-service program, mainly through the activities of CMS's Medicare contractors. There are two basic types of contractors: fiscal intermediaries, who process mainly Part A claims (e.g., hospital bills) and carriers who process Part B claims (e.g., physician bills). These contractors are responsible for making timely, accurate, and fiscally responsible payments to Medicare providers and suppliers for covered health care services. In FY 2004, they will process more than one billion Medicare claims; handle more than 8 million appeals; respond to over 45 million inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS.

The Medicare Operations activity also includes Information Technology funding for critical claims processing functions, such as telecommunications, systems maintenance, and data center support. It funds a variety of projects that enhance the Medicare program and make it more efficient, such as a new accounting and financial management system for the contractors. It also supports major provisions of the Beneficiary Improvement and Protection Act of 2000, and the Health Insurance Portability and Accountability Act of 1996, including Administrative Simplification and the Privacy Regulation. In addition, it funds the National *Medicare & You* Education Program (NMEP), an initiative that educates Medicare beneficiaries so they can make informed health decisions based on accurate, reliable, relevant and understandable information. The Medicare Operations activity funds the major portion of NMEP activities which include: a Medicare handbook with area-specific information on managed care plans, a toll-free number (1-800-MEDICARE), an Internet site (www.medicare.gov), counseling and outreach, and a national ad campaign. Other sources of funding include the Medicare+Choice user fee and Quality Improvement Organization funds.

The CMS's Medicare contractors also serve as the front line in safeguarding the Medicare trust funds against fraud, waste, and abuse. These benefit integrity activities are funded separately through the Medicare Integrity Program budget and are not included in the totals shown above.

Other representative goal(s) that fit under this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-04)
- Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (MIP1-04)

- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice (FAC4-04)
- Improve the Provider Enrollment Process (MIP7-04)

Performance Goal	Targets	Actual Performance	Ref.
Improve Beneficiary Telephone Customer Service (Developmental)			MO1
--Quality of Response	**FY 04:** --Minimum of 87% pass rate for Adherence to Privacy Act --Minimum of 90% meets expectations for Customer Skills Assessment --Minimum of 87% meets expectations for Knowledge Skills Assessment	**FY 04:**	
	FY 03: --Minimum of 85% pass rate for Adherence to Privacy Act --Minimum of 90% meets expectations for Customer Skills Assessment --Minimum of 85% meets expectations for Knowledge Skills Assessment	**FY 03**:	
-- Expansion of 1-800-MEDICARE number and desktop rollout	**FY 04**: Continue expansion efforts	**FY 04**:	
	FY 03: Begin expansion efforts	**FY 03**:	

Performance Goal	Targets	Actual Performance	Ref.
Improve Beneficiary Telephone Customer Service (Developmental) -- Accessibility * Busy rate * Answer time	**FY 03:** Not continued **FY 02:** Set baselines/future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** N/A **FY 02:** (Goal not met) **FY 01:** Data being collected (Goal met) **FY 00:** Data necessary to determine baselines/targets are expected by the end of FY 2002. (Goal not met)	MO1 See FY 03 Revised Final
-- Accuracy of Response	**FY 02:** Set baselines/future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 02:** See above (Goal met) **FY 01:** Data being collected. (Goal met) **FY 00:** Data necessary to determine baseline/target are expected by the end of FY 2002. (Goal not met)	
-- Caller Satisfaction ****Shading indicates the goal's targets prior to the current revision.**	**FY 03:** Not continued **FY 02:** Set baselines/future targets **FY 01:** Continue data collection **FY 00:** Develop baselines and targets	**FY 03:** N/A **FY 02: (**Goal not met) **FY 01:** Data being collected. (Goal met) **FY 00:** Data necessary to determine baseline/target are expected by the end of FY 2002. (Goal not met)	
Medicare Payment Timeliness Consistent w/Statutory Floor and Ceiling Requirements	**FY 04:** Same as FY 2003 **FY 03:** Same as FY 2002 **FY 02:** Same as FY 2001 **FY 01:** Maintain payment timeliness at the statutory requirement for electronic bills/claims **FY 00:** Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment	**FY 04**: **FY 03:** **FY 02: Intermediaries** 99.7% (Goal met); **Carriers** 99.5% (Goal met) **FY 01: Intermediaries** 99.2% (Goal met); **Carriers** 98.7% (Goal met) **FY 00: Intermediaries** 99.4% (Goal met); **Carriers** 99.6% (Goal met) **FY 99: Intermediaries** – 99.6%; **Carriers** – 99.4% **FY 98:** 95 percent of both **Part A** clean, electronically submitted non-Periodic Interim Payment bills and **Part B** clean electronically submitted claims are processed within 14-30 days of receipt **(Baseline)**	MO2 

Performance Goal	Targets	Actual Performance	Ref.
Increase Use of Electronic Commerce/Standards in Medicare			MO3 
-- Maintain high percentage of electronic media claims (EMC) for fiscal intermediaries (FIs)	**FY 04:** 97% **FY 03:** 97% **FY 02:** 97% **FY 01:** 97% **FY 00:** 97% **FY 99:** 97%	**FY 04:** **FY 03:** **FY 02:** 98% (Goal met) **FY 01:** 97.7% (Goal met) **FY 00:** 97.4% (Goal met) **FY 99:** 97.1%	
-- Maintain high percentage of EMC for carriers	**FY 04**: 80% **FY 03:** 80% **FY 02:** 80% **FY 01:** 80% **FY 00:** 80% **FY 99:** 80%	**FY 04**: **FY 03:** **FY 02:** 83.7% (Goal met) **FY 01:** 83.0% (Goal met) **FY 00:** 81.9% (Goal met) **FY 99:** 80.9%	
-- Implement HIPAA standards	**FY 04**: TBD **FY 03:** Complete claim status, eligibility inquiry, prior authorization, and retail drug standards implementation and testing. **FY 02:** Complete implementation of HIPAA EDI standards for claims, COB and ERA. Begin implementation for claims status and eligibility inquiries. **FY 01:** Begin testing and implementation of HIPAA EDI standards	**FY 04**: **FY 03:** **FY 02:** Completed Medicare implementation of HIPAA EDI standards for claims, COB, and ERA. Implementation for claims status and eligibility inquiries started. (Goal met) **FY 01:** Instructions for testing and implementation of the HIPAA EDI standards were issued in FY 2001 (except for the eligibility inquiry and response transaction). Due to competing project priorities, implementation and testing of other HIPAA EDI standards needed to be delayed until FY 2002. (Goal not met)	
Develop baseline data for electronic claims status, electronic eligibility queries, ERA, EFT and COB transactions	**FY 03:** Complete Baseline **FY 02:** Continue to develop Baseline **FY 01:** Develop Baseline	**FY 03:** **FY 02:** Baseline data collection to begin for carriers effective 04/1/03. Intermediary collection to be scheduled. **FY 01:** Funding was requested for this work for FY 01 and FY 02 but not available as needed for higher priority projects. As a result, system changes to enable baseline data to be collected was deferred to FY 03.	

Performance Goal	Targets	Actual Performance	Ref.
Improve CMS's Rating on Financial Statements	**FY 04:** Maintain a "clean" opinion on the FY 2004 financial statements. **FY 03:** Maintain a "clean" opinion on the FY 2003 financial statement **FY 02:** Maintain a "clean" opinion on the FY 2002 financial statement **FY 01:** Maintain a "clean" opinion on the FY 2001 financial statement **FY 00:** Maintain a "clean" opinion on the FY 2000 financial statement **FY 99:** Achieve a "clean" opinion on the FY 1999 financial statement	**FY 04:** **FY 03:** **FY 02:** (Goal met) **FY 01:** (Goal met) **(NEW DATA)** **FY 00:** (Goal met) **FY 99:** (Goal met) **FY 98:** Qualified opinion **(Baseline)** **FY 97:** Qualified opinion **FY 96:** Disclaimer on audit	MO4 
Improve CMS oversight of Medicare Fee-for-Service contractors (Developmental)	**FY 04:** Developmental **FY 03:** Building on prior year's experience. **FY 02:** Building on experience of FY 2001 **FY 01:** Building on progress achieved in FY 1999 and FY 2000 CMS will move further toward its goal of national, uniform contractor evaluation.	**FY 04:** **FY 03:** **FY 02: (**Goal met.) **FY 01:** (Goal met) **FY 00:** Inconsistency in reporting **(Baseline)**	MO5 **5, 8** 
Increase eligible delinquent debt referred for cross servicing to the Program Support Center	**FY 04:** Same as FY 2003 **FY 03:** --Continue to refer 100% of eligible delinquent CMS receivables to Treasury. --Improve the procedures for identifying, monitoring and tracking these debts. **FY 02:** Increase dollar amount of debt referred for cross servicing to 100% of eligible delinquent debt	**FY 04:** **FY 03:** **FY 02:** Referred 90% of eligible debt. Remaining debt to be referred first part of FY 2003. (Goal not met) **FY 01:** $2.1 billion delinquent debt referred **FY 00:** We referred approximately $2 billion in delinquent debt. This equals about 25% of eligible debt **(Baseline)**	MO6 

Performance Goal	Targets	Actual Performance	Ref.
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service through implementation of the Medicare Summary Notice (MSN)	**FY 03:** Goal discontinued due to completion of implementation **FY 02:** Complete national implementation **FY 01:** Same as FY 2000 **FY 00:** Support MSN efforts, aiming toward full implementation FY 2002	**FY 03:** Goal discontinued **FY 02:** National MSN implementation has been completed (Goal met) **FY 01:** Carrier/FI MSN implementation at 81%. Contractor support ongoing. (Goal met) **FY 00:** Carrier/FI MSN implementation at 81% (Goal met) **FY 99:** Carrier/FI MSN implementation at 75% **FY 97:** Beneficiaries received various notices indicating claims activity for most Part A and Part B services **(Baseline)**	MO7
Improve effectiveness of dissemination of Medicare information to beneficiaries (5-year targets): --Accessibility of Information Collect and monitor data to achieve by FY 2004 percentage of beneficiaries who sought Medicare information from Medicare sources and reported the information received answered their question(s).	**FY 04:** 77% **FY 03:** Collect/monitor data **FY 02**: Collect/monitor data **FY 01**: Collect/monitor data **FY 00**: Collect/monitor data	**FY 04:** **FY 03:** **FY 02**: Data collected/monitored (Goal met) **FY 01**: Data collected/monitored (Goal met) **FY 00**: Though single-year MCBS data are not statistically meaningful for this goal, we are on track to meet our target by FY 2004 **FY 99**: 67% **(Baseline)**	MO8 **3, 5** See FY 03 Revised Final
--Awareness of Messages Collect and monitor data to achieve by FY 2004 percentage of beneficiaries who knew that most people covered by Medicare may select from among different health plan options within Medicare.	**FY 04:** 57% **FY 03:** Collect/monitor data **FY 02**: Collect/monitor data **FY 01**: Collect/monitor data **FY 00**: Collect/monitor data	**FY 04:** **FY 03:** **FY 02**: Data collected/monitored (Goal met) **FY 01**: Data collected/monitored (Goal met) **FY 00**: Though single-year MCBS data are not statistically meaningful for this goal, we are on track to meet our target by FY 2004 **FY 99**: 47% **(Baseline)**	

Performance Goal	Targets	Actual Performance	Ref.
Improve beneficiary understanding of basic features of the Medicare program by: (1) Increasing number of questions correctly answered by beneficiaries to measure understanding of different components of Medicare (2) Increasing percentage of beneficiaries aware of 1-800 MEDICARE number	**FY 04**: (1) 3.50 out of 6 questions (2) 65% of beneficiaries **FY 03:** Continue to collect & monitor data **FY 02:** Baselines/future targets to be developed **FY 01:** (1) Develop list of core features (2) Obtain advisory input (3) Design and test survey questions (4) Integrate questions (5) Field questions	**FY 04:** **FY 03:** **FY 02:** Baselines/targets developed (Goal met) **FY 01**: Steps 1-5 completed. Survey fielded (Goal met) **CY 00:** (1) 2.75 out of 6 questions (2) 53% of beneficiaries **(Baselines)**	MO9 **3, 5**  See FY 03 Revised Final

Performance Results Discussion

Fee-for-Service Telephone Customer Service – To improve fee-for-service (FFS) telephone customer service, CMS is "raising the bar" with respect to quality standards to keep up with industry norms and customer expectations. Initially for FY 2000-2002, our intent was to measure beneficiary customer service in three areas: accessibility, accuracy of response, and caller satisfaction. Once consistent standards were developed for all contractors, CMS was able to continue to collect data for these measures, meeting our FY 2001 goal. However, due to technical difficulties, our FY 2001 conversion to the FTS-2001 long distance service provider (WorldCom) took longer than expected requiring an extension of the future data collection period for the accessibility measure. Recently, a change in Agency priorities and the strategy for telephone customer service required a redirection of funding for the national caller satisfaction survey to a pilot operation in Pennsylvania (beneficiaries calling a single 800 number), in early FY 2002. This important pilot is a model for how CMS will handle calls in the future, and the future focus of this goal will track the nationwide implementation of this toll free number.

The CMS also made the development and implementation of a standard desktop for customer service representatives (CSRs) at contractor call centers one of its highest priorities in telephone delivery. This desktop, Next Generation Desktop, is scheduled to be rolled out to the call centers during FY 2003 – 2004, and will result in significant improvements in the call centers, by increasing the consistency and accuracy of responses to beneficiary inquiries, ultimately increasing their satisfaction with the telephone interaction. However, given the lack of baseline data and the anticipated initial impact of the new desktop tool, CMS cannot establish realistic performance targets for caller satisfaction for several years to come. This lack of baseline data, along with the change in Agency priorities has resulted in the discontinuation of the caller satisfaction and accessibility measures at this time.

Fee-for-Service Medicare Payment Timeliness – For FY 2002, we were successful in achieving payment timeliness of electronic claims at 99.7 percent for intermediaries and 99.5 percent for carriers. We will continue to maintain payment timeliness performance at a level that meets the statutory requirement for payment of electronic claims.

Electronic Commerce – For the FY 2002 Electronic Commerce goal, we were successful in maintaining high percentages of electronic media claims of 98 percent and 83.7 percent for fiscal intermediaries and carriers, respectively. The CMS is performing ongoing work with Health Insurance Portability & Accountability Act (HIPAA) electronic standards development for the health care environment. In FY 2001, we began implementing HIPAA Electronic Data Interchange standards, and continued the work in FY 2002. We will continue our work on implementation of standard transactions in FY 2003.

Programming and preliminary testing for implementation of the HIPAA claim standard was completed in FY 2002. Programming hours and funding to enable completion of implementation and testing for each of the HIPAA standards were unavailable in FY 2001 because of changes in agency project prioritization. As a result, some of the work was deferred until FY 2002 and FY 2003. In addition, due to the complexity of implementation of these standards, contractor programming hour estimates increased resulting in completion of less work, but at a higher cost than initially anticipated. HIPAA requires that the Secretary adopt national health care EDI standards for at least the nine transaction types specified in the legislation. As a result of a redirection of funding and available programming hours, it was not possible to schedule implementation and testing of the transactions for prior authorization and retail drugs until FY 2003. Those standards, as well as work deferred from FY 2001 and FY 2002 as described above, are now included in the targets established for FY 2003.

Chief Financial Officer's Report – The CMS financial statements are a material element of both the Department of Health and Human Services financial statements and the government-wide financial statements required by the CFO Act of 1990 and the Government Management and Reform Act (GMRA). The CMS met its goal to maintain a “clean” unqualified opinion on FY 2002 financial statement.

During FY 2002, we tested financial management internal controls at 15 Medicare contractors using Certified Public Accounting (CPA) firms, conducted contractor performance evaluation reviews of financial management issues at 6 Medicare contractors, and reviewed accounts receivable balances at 12 Medicare contractors using CPA firms. In addition, we continued to develop the analytical tools necessary to perform more expansive trend analysis of critical financial data to identify potential errors or misstatements. Our long-term plan is to implement an integrated general ledger accounting system.

Fee-for-Service Contractor Oversight - In an effort to improve performance and oversight of carriers and fiscal intermediaries (FI) that interact directly with CMS’s customers, CMS established several performance goals in this area. The CMS can

provide better oversight of our contractors by using a standardized, uniform evaluation process. In 2001 national teams using standardized review protocols conducted 171 onsite reviews. In 2002, national teams using standardized evaluation protocols conducted 132 onsite reviews. Greater review consistency has been achieved through the increased use of national (regional office/central office) review teams, development and use of standard review protocols, and conducting national conferences and training for reviewers. We are looking forward to continued improvement through the use of performance information to guide our contractor oversight activities.

Delinquent Debt - The CMS worked hard to meet its goal of referring 100 percent of all eligible delinquent debt. However, due to the various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated. Therefore, the CMS managed to refer approximately 90 percent of its eligible delinquent debt by the end of the fiscal year. The balance of eligible debt will be referred in FY 2003. In order to improve performance, CMS has established workgroups that will assist in identifying various types of debts and establishing improved procedures for referring the debt for cross servicing.

Beneficiary Information/Fee-for-Service (Medicare Summary Notice--MSN) - National implementation of the MSN is expected to improve effectiveness of information for beneficiaries enrolled in the fee-for-service program. Because this monthly information will be in a more clear, understandable format than previous multiple notices, it is also expected to be easier for beneficiaries to spot inconsistencies or instances of fraud. In FY 2001, we supported, and will continue to support, the Medicare contractors that have already implemented the MSN by answering questions, solving problems, considering suggestions, etc. We will also continue to handle Congressional, beneficiary, contractor, and beneficiary advocacy group inquiries relating to the MSN in general and to the resulting confusion beneficiaries may feel due to receiving the MSN in some instances and different benefit notices (Explanation of Medicare Benefits, Notice of Utilization, and Explanation of Benefits) in other instances. We have now met our FY 2002 goal of nationwide implementation of the MSN.

Beneficiary Information - With clear baselines in place, we continue to track our beneficiary education efforts toward our ultimate 5-year target beneficiary accessibility and understanding of educational efforts in the area of the Medicare+Choice program. Feedback from surveys of beneficiaries receiving the *Medicare & You* handbook has been positive, and the number of beneficiaries calling CMS's toll-free number (1-800-MEDICARE) continues to increase with positive feedback. The beneficiary-centered website (www.medicare.gov) also continues to be popular, and data collected from the website's feedback form demonstrate high user satisfaction. These efforts, along with other national and local programs, strive to raise beneficiary awareness from different perspectives; e.g., through the Quality Improvement Organizations' public nursing home campaigns.

In Fall 2001 and 2002, CMS embarked on a national ad campaign which has helped beneficiaries and their caregivers become active and informed participants in their health

care decisions. We implemented a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. This included:

- expanding customer service representative availability at 1-800-MEDICARE to 24 hours a day, 7 days a week;
- introducing a web-based Medicare Personal Plan Finder on www.medicare.gov to help consumers compare their health plan choices (M+C plans, Medicare Fee-for-Service, and Medigap plans);
- enabling customer service representatives at 1-800-MEDICARE to provide more in-depth help to callers on finding the health plan choice that is best for them; and
- conducting a national ad campaign on the new choices and new ways to get information.

These strategies will contribute to many important Agency efforts and will support several performance goals, including our goals to improve beneficiary understanding of basic features of the Medicare program (MO9-04) and to increase adult immunization (QIO2-04) and mammography rates (QIO3-04). We plan to conduct another national media campaign in Fall 2003 to continue our promotion of the Medicare program.

Beneficiary Understanding - To promote beneficiary and public understanding of CMS and its programs, we have developed a goal to improve and measure beneficiary awareness of (1) the core features of Medicare needed to use the program effectively, and (2) CMS sources from which additional information can be obtained. We will measure beneficiary awareness and understanding of the Medicare program using the Medicare Current Beneficiary Survey. The first measure is to improve the number of questions about the Medicare program answered correctly out of six questions on a knowledge quiz. The second measure is to improve beneficiary awareness of the 1-800-MEDICARE information number.

Performance Goal MO1-04

Improve Beneficiary Telephone Customer Service

Baseline: National quality targets defined. Currently no standardization of telephone call centers; 1 pilot underway.
FY 2004 Target: (1) Quality Standards: --Minimum of 87 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 87 percent meets expectations for Knowledge Skills Assessment (2) Continue national expansion of 1-800-MEDICARE.
FY 2003 Target: (1) Quality Standards: --Minimum of 85 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 85 percent meets expectations for Knowledge Skills Assessment (2) Begin national expansion of 1-800-MEDICARE.
FY 2002: New in FY 2003

Baseline: Developmental. Baseline data on accessibility, accuracy of response, and caller satisfaction are being collected and will be available by the end of FY 2002.
FY 2002 Target: Complete data collection and set baselines/future targets. **Performance:** Goal partially met. Accuracy standards were set (see Quality Standards, above). Accessibility and caller satisfaction measures discontinued due to shift in focus in the delivery of beneficiary telephone customer service.
FY 2001 Target: Continue data collection for accessibility, accuracy of response, and caller satisfaction measures (revised due to unavailability of accurate data until FY 2002). **Performance:** Goal met. Data collection continuing.
FY 2000 Target: Develop baselines and targets by the end of FY 2000 in areas of accessibility, accuracy of response, and caller satisfaction. **Performance:** Goal not met.

Discussion: Medicare carriers handle nearly 18 million telephone beneficiary inquiries annually. Beneficiary telephone customer service is a central part of CMS's customer service function, and we are developing a long-term and comprehensive strategy to deliver efficient, informative and customer-focused telephone service for our beneficiaries.

Although our previous goal (FY 2000-02) focused on measuring improvements in accessibility, accuracy of response, and caller satisfaction, our new goal focuses on the nationwide implementation of a single 800 number for beneficiary inquiries. This shift reflects a significant systems change that will enhance contractor efficiency and also improve responsiveness to our beneficiaries. We will continue to measure the quality standards that we have built over the last few years while we introduce improvements in telephone customer service via the 1-800-MEDICARE line nationwide.

Currently, the 1-800-MEDICARE number is a helpline for general Medicare questions unrelated to specific claims or individual beneficiaries; our planned expansion will allow

personalized customer service via the 800 number. This goal focuses on improvements at the carrier and fiscal intermediary level; these services will ultimately be rolled into a single 800 number that will route customers to the appropriate Medicare contractor call centers. The CMS presently allows each Medicare contractor to have numerous toll-free numbers for managing their Medicare telephone inquiries. This has proven to be confusing to the public and prevents us from managing our call volumes in an orderly and efficient manner. In addition, based on statistics, we answer over 18 million calls a year; however, we receive almost 30 million call attempts a year to all of our toll-free numbers. This means that a large percentage of our calls go unanswered each year. A single 800 number will provide one point of contact for the calling public.

Our long-term strategy will be to make this 800 number a single entry point into the network, providing economies of scale, and to utilize resources by seamlessly shifting from over utilized to underutilized call centers. This will: (1) capture many of the calls that were not getting through, and (2) reduce the number of callers who dial one number and are referred to another (currently, 25 percent of the callers to the 1-800-MEDICARE line are referred to their carrier's 800 number). All call centers will have access to the systems housing beneficiary information and will be equipped with scripts to enable the customer service representatives to handle any question, regardless of which call center is being used. Currently, an 800 number pilot project in Pennsylvania is a model for how CMS will handle calls in the future.

Another critical strategy is the development and implementation of a standard desktop for customer service representatives at the contractor call centers. Customer service representatives at one Durable Medical Equipment Regional Carrier were trained on this desktop in late FY 2002. After it is pilot tested, this desktop will be rolled out to the remaining call centers over the next couple of years. The new desktop tool is designed to increase the consistency and accuracy of all responses to beneficiary inquiries and thus will ultimately increase the customers' satisfaction with the telephone interaction.

Coordination: The CMS will work closely with its contractors during the data collection process for our quality measures and implementation of the desktop toward national implementation of 1-800-MEDICARE.

Data Source(s): As reviewers/auditors monitor a sample of calls for each customer service representative, they record the assessment of performance on standardized Quality Call Monitoring scorecards. Criteria for rating all aspects of call handling are also standardized. Accuracy and overall quality of the calls handled are reported monthly to CMS's Customer Service Assessment and Management System using scorecard totals.

Verification and Validation: Data reported by carriers are routinely reviewed by CMS Regional Offices as part of the contractor performance evaluation process. In addition, contractor reporting is reviewed on a regular basis by CMS for compliance with established standards. The CMS plans to validate the data on accuracy of response by having an independent third party sample a minimum of calls.

Performance Goal MO2-04

Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements

Baseline: In the baseline year FY 1998, intermediaries and carriers, respectively, met statutory requirements that 95 percent of clean, electronically submitted non-Periodic Interim Payment electronic bills and 95 percent of clean, electronically submitted claims are processed between 14-30 days of receipt.
FY 2004 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
FY 2003 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
FY 2002 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims. **Performance:** Goal Met
FY 2001 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims. **Performance:** Goal Met
FY 2000 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims in a millennium compliant environment. **Performance:** Goal Met

Discussion: The Social Security Act, sections 1816 (c)(2) and 1842 (c)(2) establish mandatory timeliness requirements for Medicare claims payment to providers of services. As a result, Medicare intermediaries and carriers are required to pay 95 percent of clean electronic media bills/claims between 14 to 30 days from the date of receipt. This requirement does not include Periodic Interim Payment bills.

Medicare contractors have traditionally satisfied CMS's bill/claim processing timeliness requirements. Medicare contractors are under added pressure to sustain performance with increased efforts directed at decreasing the number of Medicare payments that are attributed to fraudulent or abusive billing. However, CMS has identified bill/claim-processing timeliness as a priority area. To that end, Medicare contractors are required to maintain the statutory level of bill/claim processing timeliness performance while strengthening their ability to deter fraud and abuse in the Medicare program. The final data for FY 2002 showed a payment rate for intermediaries of 99.7 percent and 99.5 percent for carriers.

Coordination: The CMS is committed to being a reliable business partner for the provider community. The CMS works closely with its contractors to ensure that payment timeliness requirements are met.

Data Source(s): The primary data source is the Contractor Reporting of Operational and Workload Data (CROWD) system. CROWD contains contractor-specific bills/claims processing timeliness rates. Success in achieving the desired target will be measured at the national level.

Verification and Validation: The CMS routinely utilizes Contractor Performance Evaluation (CPE) for determining claims processing timeliness. Through CPE, CMS measures and evaluates Medicare contractor performance to determine compliance with specific responsibilities defined in the contract with CMS, and also responsibilities outlined in Medicare law, regulations, and instructions.

Performance Goal MO3-04

Increase the Use of Electronic Commerce/Standards in Medicare

Baseline: In the baseline year FY 1999, intermediaries and carriers, respectively, reached Electronic Media Claim (EMC) rates of 97.1 percent and 80.9 percent.
FY 2004 Target: The FY 2004 target EMC rates will remain at 97 percent and 80 percent for intermediaries and carriers, respectively.
FY 2003 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after FY 2005*, when initial Health Insurance Portability and Accountability Act (HIPAA) standards should have been implemented throughout the industry. (b) Complete baseline data for electronic claims status, electronic eligibility queries, electronic remittance advice (ERA), electronic funds transfer (EFT), and coordination of benefits (COB) transactions. (c) Complete implementation and testing of the HIPAA electronic transaction standards for: claims status and response, eligibility inquiry and response, prior authorization, and retail drugs claims, payments and inquiries. (d) Begin implementation of the HIPAA transaction standard for attachments. *Delayed from FY 2004
FY 2002 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after FY 2005* when Health Insurance Portability and Accountability Act (HIPAA) standards are implemented throughout the industry, and the resulting issues have been satisfactorily resolved. (b) Complete implementation and testing, at Medicare contractor sites of the HIPAA Electronic Data Interchange (EDI) standards for the following Medicare transactions: electronic claims and COB, and the ERA. Begin implementation activities for the eligibility inquiries and response, and claims status inquiry and response transactions. *Delayed from FY 2003 **Performance:** Goal Met
FY 2001 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. (b) In the third quarter of FY 2001 begin to establish baseline data for electronic claims status, electronic eligibility inquiries, Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) transactions. (c) Begin implementation and testing, at Medicare contractor sites, the HIPAA EDI standards for the following Medicare transactions: electronic claims and coordination of benefits, ERA, eligibility inquiries and response, and claims status inquiry and response. **Performance:** Goal Partially Met
FY 2000 Target: Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers through FY 2000. **Performance:** Goal Met

Discussion: The objective of this performance goal is to maintain, and, in the long-run, increase the percentage of activities accomplished electronically, rather than on paper form, on the telephone, or through other manual means. Increasing standardization and increasing the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars.

HIPAA requires that the Secretary of HHS adopt, at a minimum, standardized electronic formats and data contents for claims, COB, ERA, claims status inquiry/response, eligibility inquiry/response, prior authorization, retail drugs processing, and attachments

for use by the entire U.S. health care payment industry. The Secretary is encouraged to adopt further standards as warranted, and is also required to periodically adopt updates to or replacements for the previously published standards. As a result, HIPAA transaction standards implementation and maintenance will be an ongoing project for Medicare.

Within two years of publication of the final rule for each standard, health care plans and providers of service that engage in electronic health care commerce are required to utilize the standards required under HIPAA (small plans have three years), and are prohibited from use of similar but non-compliant EDI transaction formats. The initial HIPAA transactions final rule was published in August 2000, but most Medicare contractor implementation activities could not begin until FY 2002 due to the need to assign available contractor programming hours and funds to projects determined to be a higher priority. This led to the deferral of a number of HIPAA implementation activities from FY 2001 to FY 2002 or FY 2003. This has been further delayed due to the passing of Public Law 107-105 in December 2001. The Administrative Simplification Compliance Act (ASCA) has given covered entities the option to obtain an extension for compliance to October 16, 2003 from October 16, 2002, giving the Medicare program an additional year to become HIPAA compliant. Medicare has filed for an extension as required under ASCA.

Over the last decade, CMS has placed a great emphasis on the use of electronic claims transmissions. The final data for FY 2002 showed an electronic claims submission rate of 98 percent for intermediaries and 83.7 percent for carriers. These rates are at or near a natural saturation point. We believe maintenance of EMC will be challenging in FY 2003 and FY 2004 given the HIPAA pre-implementation environment across the health care industry. However, the requirement for electronic claim submission under ASCA will help in maintaining and eventually increase the high level of EMC reached in previous years.

As Medicare providers begin to focus on the standards under HIPAA, we believe they will slow their EDI investments as they prepare for the new standards. This could result in at best, no increase in use of electronic transactions during the transition period to full use of the HIPAA standards. At worst, this could result in a temporary reduction of provider use of EDI if they wait for the industry to complete HIPAA implementation and work out any resulting problems. It is not realistic to expect any increase in provider EDI use during this transaction flux.

Our approach, therefore, has been to set targets on maintenance of electronic claims levels during this transition, implementation and testing of HIPAA standards, development of baseline measurements for other EDI transactions, and establishment of targets for these transactions. The target of establishing baseline data for electronic claim status, electronic eligibility inquiries, Electronic Remittance Advice and Electronic Funds Transfer in the third quarter of FY 2001 and in FY 2002 was delayed due to lack of funding. Collection of baseline data for carriers will begin April 1, 2003. Intermediary collection still needs to be scheduled.

Coordination: The CMS works closely with Medicare contractors in the development of EMC payment rates, and with Medicare contractors and Standard Developing Organizations (e.g., X12) in developing HIPAA standards.

Data Source(s): The data source for tracking EMC is CMS's Contractor Reporting of Operational and Workload Data (CROWD) system. Medicare contractors have started to separately report to CMS on status of HIPAA standards implementation and testing in FY 2002. In FY 2003, performance statistics should begin to be collected through the CROWD system for EDI transactions in addition to claims, if funding is available.

Verification and Validation: The CMS routinely utilizes the Contractor Performance Evaluation (CPE) for evaluating the accuracy of contractor data reporting, including CROWD. The CPE measures and evaluates contractor performance to determine if contractors meet specific responsibilities defined in the contract between CMS and the contractor, and also responsibilities outlined in Medicare law, regulations, and instructions. In addition, CMS has contracted with an IV & V company to conduct HIPAA-specific evaluations to validate Medicare contractor compliance with the adopted EDI standards. These verification and validation activities should be in effect through FY 2002, and will end in early FY 2003.

Performance Goal MO4-04

Maintain CMS's Improved Rating on Financial Statements

Baseline: In the FY 1998 financial statements, one item totaling $3.6 billion was questioned by the auditors, resulting in a qualified opinion.
FY 2004 Target: Maintain a "clean" unqualified opinion on CMS's FY 2004 financial statements.
FY 2003 Target: Maintain a "clean" unqualified opinion on CMS's FY 2003 financial statements.
FY 2002 Target: Maintain a "clean" unqualified opinion on CMS's FY 2002 financial statements. **Performance:** Goal met.
FY 2001 Target: Maintain a "clean" unqualified opinion on CMS's FY 2001 financial statements. **Performance:** Goal met.
FY 2000 Target: Maintain a "clean" unqualified opinion on CMS's FY 2000 financial statements. **Performance:** Goal met.
FY 1999 Target: Achieve a "clean" unqualified opinion on CMS's FY 1999 financial statements. **Performance:** Goal met.

Discussion: Our goal is to maintain an unqualified opinion, which indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and financing of CMS. Auditors review the financial operations, internal controls, and compliance with laws and regulations at CMS and its Medicare contractors.

Since FY 1998, we have made significant improvements on our financial statements. On the FY 1998 statements, we obtained a qualified opinion because the auditors found deficiencies in several aspects of the Medicare contractors' accounts receivable: (1) inadequate supporting documents to validate accounts receivable balances, and (2) inability to reconcile subsidiary financial records to the accounting reports submitted to CMS.

In FYs 1999, 2000, 2001, and 2002, CMS received unqualified audit opinions. During FY 2002, we tested financial management internal controls and reviewed accounts receivable balances at 15 Medicare contractors using Certified Public Accounting (CPA) firms. In addition, we created workgroups comprised of Central Office (CO) and Regional Office (RO) consortia staff responsible for addressing four key areas identified by auditors: follow up on corrective action plans (CAPs), reconciliations of funds expended to paid claims, trend analysis, and internal controls. The objectives of each workgroup are to clearly define CO and RO roles and responsibilities, as well as develop the national strategic plans to strengthen our Medicare contractor financial management oversight in these areas. Our long-term plan is to implement an integrated general ledger accounting system.

Coordination: This goal requires coordination with the Office of Inspector General (OIG), CMS internal financial components, CMS regional offices, Medicare contractors, and Medicaid State Agencies.

Data Source(s): The audit report of CMS's financial statements is issued by a CPA firm with oversight by the OIG.

Verification and Validation: The CMS works closely with the OIG and CPA firms during the audit and has the opportunity to review, discuss, and/or clarify the "Findings and Conclusions" presented. The General Accounting Office (GAO) has responsibility for the opinion on the consolidated government-wide financial statements, which includes oversight for the audit of the Department of Health and Human Services, of which CMS's outlays are approximately 83 percent.

Performance Goal MO5-04

Improve CMS Oversight of Medicare Fee-for-Service Contractors

Baseline: Developmental. There was extensive variation in the format of reports and review protocols and timeliness of report submission during the period from FY 1995 to FY 1998.
FY 2004 Target: Developmental.
FY 2003 Target: Building on program achievement in prior years, CMS will move still further toward its goal of national uniform contractor evaluation.
FY 2002 Target: Building on experience of FY 2001 and continuing towards goal of national uniform contractor evaluation. **Performance:** Goal Met
FY 2001 Target: Building on progress achieved in FY 1999 and FY 2000, CMS will move further toward its goal of national, uniform contractor evaluation. **Performance:** Goal Met

Discussion: In FY 2001, Medicare fee-for-service payment contractors received approximately $1.45 billion in program management and Medicare Integrity Program funding to process nearly 931 million claims and administer benefit outlays of approximately $197 billion. In FY 2003, they will process an estimated 1 billion Medicare claims; handle more than 7 million appeals; respond to over 40 million inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS.

In FY 1995, CMS decentralized its approach to evaluating these contractors and afforded considerable flexibility to CMS regional offices in planning and conducting evaluations of contractors within each region. Decentralization of these reviews produced inconsistency from region to region, and difficulty in assessing national contractor performance.

Beginning in FY 1999 and continuing in FY 2000 and FY 2001, CMS focused on contractor performance evaluation (CPE) through a risk-based, consistent national approach to contractor review that allocates resources to evaluating high-risk contractors and/or program benefits. The criteria for selecting additional contractors for more intensive review include: claims volume, administrative costs, benefit payout, integrity issues and past performance.

In 2001, all onsite reviews were conducted by national teams using standardized review protocols, under the guidance of the same project leaders assigned to each business function. There were 171 onsite regional office/central office (RO/CO) and multi-regional team reviews completed in 15 business functions. There were 600 additional desk reviews completed using contractor operational data. Greater review consistency was achieved through the increased use of national (RO/CO) review teams trained to evaluate functions performed by these high-risk contractors. Several contractor activities, such as accounts receivable, computer systems security, and the effectiveness

of contractor financial internal controls, were evaluated through contracts with consulting or accounting firms, which used a standard review program.

In 2002, national (RO/CO) teams conducted evaluations using standardized protocols on which they had received training. Project Leaders, each assigned to a single business function, provided guidance to the teams evaluating the function and were responsible for approving the final evaluation reports issued to contractors. A total of 132 RO/CO teams conducted onsite reviews in 13 different business functions. Nearly 500 additional desk reviews, conducted by reviewing contractor operational data, were also performed.

We are achieving greater review consistency through the increased use of national (RO/CO) review teams trained to evaluate functions performed by the Medicare contractors. Additional steps have been taken to foster greater consistency including: standardizing review protocols, national training on the protocols, training by USDA's Government Audit Training Institute on approaches to performance audits, standardizing CPE review reports and management reports, performing a quality review in central office of each report concurrent with the Project Leader's review of the draft, and reviewing evaluators' work papers for a limited number of reviews in each business function. Finally, through contracts with consulting or accounting firms, some contractor activities such as accounts receivable and the effectiveness of contractor financial internal controls were evaluated through reviews conducted by consulting CPA firms.

Coordination: CPE coordinates closely with management and staff from CMS's central and regional offices. Working with the regions, CO managers with responsibility for the various business functions set annual evaluation priorities and develop standard review protocols utilized by the review teams. These same CO components name technical assistants who help by training the reviewers on the evaluation protocols and provide any needed technical guidance throughout the evaluation period. In the future, we will coordinate still further within CMS, which plans to use contracted SAS-70 reviews.

Data Source(s): Data on the extent of use of contractor review teams and the timeliness of issuance of each Report of Contractor Performance will be available through internal management reporting.

Verification and Validation: The CMS staff will review the reports cited under data sources to assess performance and report on progress.

Performance Goal MO6-04

Increase Referral of Eligible Delinquent Debt for Cross Servicing

Baseline: Prior to FY 2001, CMS referred over $2 billion in eligible delinquent debt for cross servicing. This is approximately 25 percent of CMS's eligible delinquent debt.
FY 2004 Target: Continue to refer 100 percent of eligible delinquent CMS receivables to Treasury. Improve the procedures for identifying, monitoring and tracking these debts.
FY 2003 Target: Continue to refer 100 percent of eligible delinquent CMS receivables to Treasury. Improve the procedures for identifying, monitoring and tracking these debts.
FY 2002 Target: Increase the dollar amount of debt referred for cross servicing to 100 percent of eligible delinquent debt. **Performance:** Goal not met. Due to various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated. The CMS referred approximately 90 percent of its eligible delinquent debt by the end of the fiscal year. The balance of eligible debt will be referred in FY 2003.

Discussion: The Debt Collection Improvement Act of 1996 (DCIA) is intended to facilitate collections by the Federal Government and to encourage the streamlining of procedures and coordination of information within and among Federal agencies. The DCIA mandates Federal agencies to refer eligible delinquent debt (180 days past due) to the Department of Treasury or a Treasury designated Debt Collection Center (DCC) for cross servicing. Debts not eligible for referral include debts: (1) in bankruptcy status, (2) with an appeal pending at any level, (3) in active litigation, or (4) where the debtor is deceased.

Prior to FY 2002, CMS referred approximately $4 billion in delinquent debt to Treasury for cross servicing and offset. By the end of FY 2002, CMS's original goal was to refer 100 percent of eligible delinquent debt. The CMS is working hard in order to meet its goal of referring 100 percent of all eligible delinquent debt. The debt referral process has become more labor intensive than we originally projected based on our pilot implementation efforts. This is because our remaining unreferred debt contains numerous debts of relatively small amounts. This debt is primarily made up of beneficiary and Medicare Secondary Payer debt. As of the end of FY 2002, CMS referred approximately 90 percent of eligible delinquent debt. The remaining debt will be referred in fiscal year 2003.

The CMS initially targeted only Medicare Part A and Part B overpayments for referral for cross servicing. However to meet our goal to refer 100 percent of eligible delinquent debt, CMS revised its debt referral procedures to utilize resources at the Medicare Contractor and Regional Office locations. These referral procedures include identifying debt eligible for referral, verifying the status and balance of the debt, certifying that the debt is valid and legally enforceable, sending a notice which apprises the debtors of their rights, and notifying the debtor of the intent to refer the debt for cross servicing.

Medicare Secondary Payer (MSP) debt, which is a large percentage of CMS's delinquent debt, was added to the referral process in FY 2001. In FY 2002, CMS began to focus on other types of debts in its accounts receivable balance, many of which reside in various databases internal to CMS.

Coordination: The CMS and the Medicare Payment Contractors, the Regional Offices and various Central Office components maintain ongoing coordination to monitor and track the debts selected for referral, debts referred, and collections received as a result of referrals. Referral efforts are coordinated with the Department of Treasury and the Program Support Center (PSC) of the Department of Health and Human Services.

Data Sources: The CMS tracks its non-MSP overpayments through the Provider Overpayment Reporting (POR) system, the Physician/Supplier Overpayment Reporting (PSOR) system, and Medicare Contractor internal systems. MSP debt information is housed in the Medicare contractor locations. Central Office debt resides on various databases and is also contained in the R321 report. Medicare contractors and CMS enter debt information into the Debt Collection System (DCS) prior to referral.

The CMS Healthcare Integrated General Ledger Accounting System (HIGLAS), which will include an accounts receivable system, is in the pilot design, development and implementation phase. This is an 18 month phase. Once implemented HIGLAS will interface with Medicare Contractor selected systems and will further streamline the current debt referral process. The implementation of this new system is expected to be completed in FY 2006.

Other types of accounts receivable, which are not housed in CMS contractor's systems, are being identified and tracked for referral to cross servicing.

Verification and Validation: Data systems outlined above will be used to track and monitor progress. At this time, the present system has limited edits to ensure data integrity. Until an integrated system is developed and implemented, CMS will monitor the data in the various systems used to ensure data integrity and consistency. The CMS will verify that the information in the DCS system is consistent with the data reported in the POR/PSOR systems. Contractor data will be verified using the Contractor Financial Reports, Statement of Financial Position (HCFA Form 750) and Status of Accounts Receivable (HCFA Form 751). In addition, CMS will request reports from the PSC on the status of debt that was referred to Treasury and other debt.

Performance Goal MO7-02

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries in Fee-for-Service *(Discontinued after FY 2002)*

Baseline: In FY 1997, beneficiaries received various notices indicating claims activity for most Part A and Part B services.
FY 2002: The CMS plans to complete national implementation of the Medicare Summary Notice (MSN). **Performance:** National MSN implementation has been completed. Goal met.
FY 2001: Same as FY 2000. (To better reflect budget linkage, this goal was moved from the Medicare+Choice User Fee budget category.) **Performance:** Carrier/FI implementation at 81 percent and contractor support ongoing. Goal met.
FY 2000: Support MSN efforts, aiming toward full implementation in FY 2002. **Performance:** Carrier/FI implementation at 81 percent. Goal met.

Discussion: To enhance beneficiary understanding of their Medicare benefits and reduce confusion over what Medicare covered for their services, CMS is continuing and, in FY 2002, completing its nationwide implementation of the MSN. The MSN combines information sent to Medicare beneficiaries on benefits received under Medicare Part A and Part B into easy-to-read monthly statements.

The MSN reduces beneficiary confusion and paperwork by providing a monthly summary of services delivered under Part A, and separate summaries for services under Part B, and durable medical equipment--like monthly credit card statements. The MSN also reduces confusion by providing claim information in a consistent format that is clearer, more concise, and easier to understand than current notices. MSN pilot test results show that beneficiaries can better understand what Medicare paid or denied and what they may owe. The MSN also contains important information regarding Medicare fraud and abuse detection, including new "Help Stop Fraud" messages to help beneficiaries identify potential fraud.

In FY 2002, we modified the Part A MSN format to incorporate the Balanced Budget Act (BBA) requirement to list the amount Medicare paid to the provider (already included in the Part B MSN). Modifications to the existing beneficiary/provider outreach and education materials will be made as a result of these changes to the MSN. The CMS has completed national MSN implementation.

Coordination: Teleconferences between CMS and fiscal intermediaries, carriers, and standard system representatives will play a critical role as CMS grows closer to national implementation of the MSN. Feedback on the MSN comes from a variety of organizations, including beneficiary advocacy groups; Medicare Quality Improvement

Organizations; State Health Insurance Assistance Programs; and Beneficiary Advisory Councils.

Data Source(s): Successful completion of the MSN will rely on the Medicare Part A, Part B, and Durable Medical Equipment Regional Carrier (DMERC) contractor systems.

Verification and Validation: The CMS oversees the performance of contractors through routinely scheduled site visits and performance reviews.

Performance Goal MO8-04

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries

Baseline: (1) In 1999, 67 percent of beneficiaries who sought Medicare information from Medicare sources reported that the information they received answered their question(s). (2) In 1999, 47 percent of beneficiaries knew that most people covered by Medicare could select from among different health plan options within Medicare.
FY 2004: Achieve (1) 77 percent of beneficiaries who reported the information they received answered their question(s), and (2) 57 percent of beneficiaries who knew that most people covered by Medicare can select from among different health plan options within Medicare.
FY 2003: Same as FY 2002/2001.
FY 2002: Same as FY 2001. **Performance:** Goal met. Data being collected and monitored.
FY 2001: Continue collecting and monitoring Medicare Current Beneficiary Survey (MCBS) data for final reporting in FY 2004. **Performance:** MCBS data being collected for the 5-year period. We are on track toward meeting the goal by FY 2004.
FY 2000: By 2004, (1) 77 percent of beneficiaries will report that the information they received answered their question(s), and (2) 57 percent will know that most people covered by Medicare can select from among different health plan options within Medicare. **Performance:** MCBS data being collected for the 5-year period. We are on track toward meeting the goal by FY 2004.

Discussion: The Balanced Budget Act (BBA) of 1997 mandated the greatest changes to Medicare since its inception. One of these changes was the expansion of health insurance options under Medicare+Choice. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the "right information at the right time."

The National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information through a variety of channels in order to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; rights, responsibilities and protections; and health behaviors. The primary objectives of the education efforts are to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the Federal Government and its private sector partners) as trusted and credible sources of information. The NMEP, along with other national and local programs strive to raise beneficiary awareness from different perspectives; e.g., through public nursing home

campaigns through the Quality Improvement Organizations. All programs are evaluated and assessed to determine their effectiveness and to implement further improvements.

In developing our targets, we assumed an average 2 percentage point increase per year; thus, 10 percentage points over the 5-year period. We figured that this was achievable given the emphasis on the education program. The targets are set for FY 2004, in order for the percentage increases to be large enough to be statistically detected.

Coordination: The CMS is continuing the process of building alliances with other consumer centered organizations to improve the dissemination of information to educate Medicare beneficiaries and those that act on their behalf. These organizations have the ability to assist us in the development and dissemination of Medicare information on a much broader basis at regional and local levels.

Data Source(s): The primary source of data on beneficiary understanding of Medicare will be the MCBS. The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. Over a 5-year period, CMS will track changes in the ability to access information and beneficiary awareness.

Verification and Validation: The MCBS is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device.

Performance Goal MO9-04

Improve Beneficiary Understanding of Basic Features of the Medicare Program

Baselines: (1) Fifty-three percent of Medicare beneficiaries were aware that Medicare has a 1-800-MEDICARE toll-free number. (2) Beneficiaries were able to answer correctly 2.75 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
FY 2004 Targets: (1) Sixty-five percent of Medicare beneficiaries are aware that Medicare has a 1-800 number. (2) Beneficiaries are able to answer correctly 3.50 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
FY 2003 Target: Continue collecting and monitoring the Medicare Current Beneficiary survey (MCBS) data for reporting on CY 2004 data.
FY 2002 Target: Developmental. Baselines and future targets will be developed. **Performance:** Goal met. Baselines and targets developed.
FY 2001 Target: Complete all actions necessary to implement a measurement and reporting system, including: (1) developing a list of core features of Medicare that beneficiaries need to know in order to use the program effectively; (2) obtaining input on the list from relevant advisory bodies; (3) designing and testing survey questions to capture the extent to which beneficiaries are aware of the basic features on the list; (4) integrating the questions into existing MCBS computer assisted personal interviewing systems; (5) fielding the questions in the spring/summer 2001 round of the MCBS. **Performance:** Goal met. Steps 1-5 completed. Survey fielded.

Discussion:
The purpose of this performance goal is not to turn every beneficiary into an expert on Medicare; consumer research has shown that beneficiaries generally seek information about the program only as specific needs arise. Our objectives in this goal are:

- to improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively, and
- to improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

As part of this goal, there are two measures. The first measure is the number of questions answered correctly out of six questions on a knowledge quiz. The quiz includes the following true/false questions:

(1) Most people covered by Medicare can select among different kinds of health plan options;
(2) Medicare without a supplemental insurance policy pays for all of your healthcare expenses;
(3) People can report complaints to Medicare about their Medicare managed care plans (HMOs) or supplemental plans if they are not satisfied with them;

(4) If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they have limited choices about what doctors they can see;
(5) If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they can change or drop the plan and still be covered by Medicare; and
(6) Medicare managed care plans (HMOs) that cover people on Medicare often cover more health services, like prescribed medicines, than Medicare without a supplemental policy.

The second measure is how many beneficiaries are aware of the CMS 1-800 MEDICARE toll-free number.

The CMS employs a variety of strategies to ensure that targeted audiences are reached with "the right information at the right time" to make informed health care decisions in order to accomplish these objectives. Ongoing formative research and consumer testing is conducted as part of all programs to ensure the development of products and information that will be understandable and delivered through the most appropriate, maximum number of information channels to reach the broadest audiences. These audiences include vulnerable populations who have problems with access to information. The CMS works across the organization to ensure maximum and efficient use of existing infrastructures to carry key Medicare messages and information to beneficiaries; e.g., expanding an existing information channel to provide new information to beneficiaries rather than building a new infrastructure. The CMS has begun to promote and publicize information channels and resources for many of our programs to further raise the awareness levels of Medicare beneficiaries.

The CMS's National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information to improve awareness of Medicare core features and sources. This program uses a variety of information channels to raise awareness including a handbook in print, toll-free telephone services through 1-800-MEDICARE, information via www.medicare.gov, and direct counseling support through the State Health Insurance & Assistance Program. NMEP along with other national and local programs strive to raise beneficiary awareness from different perspectives; e.g., public nursing home campaigns through the Quality Improvement Organizations. All programs are evaluated and assessed to determine their effectiveness and to implement further improvements.

Coordination: All CMS beneficiary-centered programs emphasize partnerships with Federal, State, local agencies, and beneficiary advocacy groups. These organizations have the ability to assist us in the development and dissemination of Medicare information on a much broader basis at regional and local levels. As an example, CMS has built an alliance network of over 120 national organizations and has formed a National Advisory Panel on Medicare Education that consists of national experts in consumer education. This panel advises the CMS Administrator on ways to enhance our efforts in consumer awareness on Medicare.

Data Source(s): The primary source of data on beneficiary understanding of Medicare will be the MCBS. The MCBS is an ongoing personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. The MCBS included questions asking beneficiaries about their awareness of basic features of the Medicare program.

Questions were in a "true," "false," or "not sure" format. For ethical reasons, after asking questions, MCBS interviewers made the correct answers to the questions available to the respondents (beneficiaries cannot inadvertently be left with any misperceptions about the program). Therefore, the act of surveying these respondents would confound subsequent measurement of their awareness of the program features. Sampled beneficiaries remain in the MCBS for 3 years and then rotate out of the survey. Thus, each year about one-third of the overall MCBS sample is new and two-thirds are returning. To avoid instrumentation bias, the questions will only be asked of new MCBS members. This new part of the MCBS sample is itself nationally representative of the Medicare population.

Verification and Validation: The MCBS is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device. All data from the MCBS are carefully edited and cleaned prior to the creation of analytic data files. Sample weights will be prepared that allow adjustments to survey estimates to account for differential probabilities of selection in the MCBS sample, under-coverage, and differential patterns of survey non-response. Statistical precision will be calculated and presented with the estimates.

Federal Administrative Costs

Federal Administrative Costs	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget*	FY 2004 Estimate
Total Budget Authority	**$504.7 M**	**$530.5 M**	**$562.5 M**	**$580.6 M**
Full-Time Equivalents	**4,610**	**4,632**	**4,661**	**4,486****

Funding for Federal Administrative Costs provides roughly 4,486** CMS employees the ability to execute the Government's responsibilities in continuing Medicare and Medicaid services. These responsibilities include providing direct program services to beneficiaries, providers, Medicare contractors, and State agencies, as well as the general public. In addition, these responsibilities include combating fraud, waste, and abuse; overseeing safety and quality of health care; promoting managed care; responding to data requests; implementing legislation; and developing efficient payment and operating systems.

* This column reflects the current estimate for FY 2003. Budget authority in the FY 2003 President's budget was $587.2 million.

** Includes 78 Full Time Equivalents (FTEs) funded by non-appropriated funds, and 10 FTEs funded through the Medicare Operations line item.

In addition to the fact that Federal Administrative Costs provide the "backbone" for most of the GPRA goals, other representative goals related to this budget category but not listed in the chart are:

- Improve Medicare Managed Care Plans' Administration of Appeal Process (MB4-04)
- Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements (MO2-04)
- Increase the Use of Electronic Commerce in Medicare (MO3-04)
- Maintain CMS's Improved Rating on Financial Statements (MO4-04)
- Improve CMS's Oversight of Contractors (MO5-04)
- Increase Referral of Eligible Delinquent Debt for Cross Servicing (MO6-04)
- Improve the Management of the Survey and Certification Budget Development and Execution Process (QSC3-04)
- Improve CMS's Information Systems Security (RP1-04)

Performance Goals	Targets	Actual Performance	Ref.
Develop and Implement an Information Technology Architecture	**FY 04:** --Continue maturing the ITA --Begin implementation of architectural support services --Implement IT policies and procedure development, as needed **FY 03:** --Continue maturing the ITA --Develop architectural support services --Implement IT policies and procedures and continue adding as needed **FY 02:** --Continue policy and procedure development --Complete development of System Design Reference Models & integration into SDLC activities -- Monitor ITA (Enterprise Architecture) conformance as part of Investment Process **FY 01:** -- Develop template configuration for major system development -- Integrate ITA into investment review process **FY 00:** Approve standards and policies for basic services (target unchanged, language was modified)	**FY 04:** **FY 03:** **FY 02:** --Established IT policy and procedure development teams. Developed and promulgated 2 policies, 15 remaining policies being drafted (Goal met) -- Development of all (8 in total) SDRMs completed 2/13/02 & projects have begun using the SDRMs in their SDLC activities. (Goal met) -- Monitoring Enterprise Architecture conformance as part of the IT Investment Management Review Process. Established baseline Products and Standards Profile. (Goal met) **FY 01:** -- Being developed; Completion of 6 templates expected 3/1/02 (Goal not met) --Integrated (Goal met) **FY 00:** All standards approved (Goal met)	FAC2 See FY 03 Revised Final
Improve CMS's Information Systems Security	See Revitalization Plan budget category		

Performance Goals	Targets	Actual Performance	Ref.
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice:	**FY 04:** -- Implement PPS system for Inpatient Psychiatric Hospital services -- Implement revised risk-adjusted payments for Managed Care **FY 03:** -- Continue design of PPS system for Inpatient Psychiatric Hospital services -- Begin combined collection of data for risk adjusted payments for Managed Care **FY02:** -- Implement Inpatient Rehabilitation Facilities PPS -- Improved risk-adjustment model for Medicare+Choice **FY 01:** -- Implement Home Health Agency PPS -- Make risk-adjusted payments based on PIP-DCG model **FY 00:** -- Implement Hospital Outpatient PPS -- Publish final HHA PPS Regulation -- Make Risk-adjusted payments **FY 99:** -- Establish SNF PPS -- Make Risk Adjusted payments	**FY 04:** **FY 03:** **FY 02:** -- IRF PPS rule published 8/7/01. Implemented 1/1/02 (Goal met) -- Inpatient/ambulatory risk-adjustment model selected (Goal met) **FY 01:** -- HHA PPS implemented 10/1/00 (Goal met) -- (Goal met) **FY 00:** -- Outpatient PPS implemented 8/1/00 (Goal met) -- Rule published 7/3/00 (Goal met) -- Risk adjusted payments began 1/1/2000 (Goal met) **FY 99:** -- (Goal met) -- (Goal met) **Baseline:** Cost reimbursement for HHA, SNF, inpatient rehab, outpatient hospital and psychiatric hospitals. Payments to managed care plans not risk-adjusted.	FAC4

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS's Workforce Planning	**FY 04:** Update workforce planning data and establish a knowledge and skill level baseline **FY 03:** Complete development of and implement automated workforce planning modules **FY 02:** Build and populate an automated workforce planning system based on work roles. - Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role. - Determine future skill and knowledge requirements.	**FY 04:** **FY 03:** **FY 02:** Developed work roles and assigned CMS positions to work roles. Determined future skills and knowledge requirements. (Goal met) **(NEW DATA)**	FAC6 See FY 03 Revised Final **8**
Improve CMS's Management Structure	**FY 04:** Establish a baseline using data from the automated management competency system. **FY 03:** (a) Implementation of a competency-based performance management (planning and appraisal) program for managers; (b) Implementation of an awards and recognition program for managers; and (c) Exploration of data sources	**FY 04:** **FY 03:**	FAC7 See FY 03 Revised Final **8**
Strengthen and Maintain Diversity at all Levels of CMS	**FY 04:** Same as FY 2003 **FY 03:** Increase representation of EEO groups in areas where they demonstrate underrepresentation	**FY 03:** **FY 02:** Progress made **FY 01:** Progress made **FY 00:** EEO groups representing manifest imbalances in CMS workforce **(Baseline)**	FAC8 **8**
Increase awareness about the opportunity to enroll in the Medicare Savings Programs	**FY 04:** Increase awareness of Medicare Savings Programs to 14% **FY 03:** Increase awareness of Medicare Savings Programs to 13% **FY 02**: Develop baseline and set future targets	**FY 04:** **FY 03:** **FY 02:** 11% (Goal met) **(Baseline)**	FAC9 **3**

Performance Goals	Targets	Actual Performance	Ref.
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization	**FY 04:** Developmental **FY 03**: -- Achieve greater administrative efficiency through consolidation of administrative functions and reduction of FTEs by 93 FTE's -- Achieve a more citizen-centered focus through organizational delayering to 4 layers	**FY 04:** **FY 03:** **FY 02:** **--**4632 FTE Ceiling **(Baseline** 1/1/02**)** --5 layers (**Baseline** 1/1/02)	FAC10

Performance Results Discussion

The CMS's Federal Administrative Budget funds a wide range of activities. Five key areas that fall under this category are: implementing the provisions of the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA); modernizing and strengthening CMS's information technology (IT) systems; improving systems security and workforce planning.

The provisions of the BBA, Balanced Budget Refinement Act (BBRA), and HIPAA made significant changes in CMS's programs. These changes were the largest the agency has seen since its inception. Two goals that support these provisions are to develop new Medicare payment systems and to ensure compliance with HIPAA.

Medicare Payment Systems – The goal to develop new payment systems in fee-for-service and Medicare+Choice measures our progress towards implementing prospective payment systems (PPS) for skilled nursing facilities, home health agencies, hospital outpatient departments, inpatient rehabilitation facilities and psychiatric hospitals. Prospective payment for these services is expected to result in more efficient provision of care and lower costs to the Medicare program.

In FY 1998, CMS began implementing a PPS for skilled nursing facilities. In FY 2000 a PPS was implemented for hospital outpatient departments. On October 1, 2000, CMS implemented a PPS for home health and we implemented PPS for inpatient rehabilitation facilities in FY 2002. Additionally, CMS will begin developing a psychiatric hospital PPS in FY 2002. Risk-adjusted payments for Medicare+Choice plans were implemented January 1, 2000 and we continue to improve the collection of data.

Information Technology Architecture (ITA) - The information technology architecture goal is designed to track the development and implementation of an IT architecture framework. We made substantial progress toward reaching our FY 2001 targets to integrate ITA requirements into our internal project review process and develop standard configuration templates. These goals were not fully met due to staffing and budget shortfalls. The ITA has been integrated into the IT Investment Management Review

process through CMS's Integrated IT Investment Management Roadmap effort. Architecture review checkpoints throughout the Roadmap are being used to ensure compliance with the ITA. The CIO Technical Advisory Board is performing this review role. A baseline IT products and standards profile has been established. We met our FY 2002 goals, as we, CMS, developed eight configuration templates (now being called "System Design Reference Models") for use in system development life cycle (SDLC) efforts. Projects have begun using the SDRM in their SDLC activities. The CMS is continuing architectural development through a segmented approach. One segment, Medicare fee-for-service claims processing, was completed in FY 2002. In addition, workgroups were established in FY 2002 to develop IT policies and procedures. Two policies were developed and promulgated. Policies in 15 remaining areas are being drafted.

Workforce Planning – To meet the rising challenge of maintaining a workforce with the specific skills necessary to accomplish our goals, and consistent with the President's Management priorities, CMS is instituting a systematic approach to assessing and addressing skills and knowledge needs. In FY 2000, CMS developed a competency catalogue of skills and knowledge required to accomplish Agency functions. This catalogue was used in FY 2001 to inventory current employee competencies.

Skill and knowledge gaps identified through this one-time data collection initiative were ranked by agency management, resulting in the identification of gaps in specific knowledge and skills. We met our FY 2002 target by developing a prototype system. Work roles were developed and assigned to all CMS positions, and future skill and knowledge requirements were determined. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. Completion of these modules is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

Management Structure – The CMS is developing a performance goal to improve our management structure. Through workforce planning, we have identified specific competency areas across the Agency that need to be targeted for improvement, including CMS's management and leadership. We will be focusing on activities such as recruitment and selection, performance management, awards and recognition, and continuous learning, to strengthen the leadership skills of our management.

In March of 2002, CMS fully implemented a competency-based recruitment and selection process. In FY 2003, we are developing an automated system (form and database) that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports. This information will allow us to measure the improvement in management competency as a result of CMS's Leadership and Management Development Strategy (LMDS) activities. We will gather baseline data from the automated system in FY 2004 to begin measuring improvement in the leadership competencies.

Workforce Diversity – We are pleased to report progress in our goal to increase representation in the CMS workforce of Equal Employment Opportunity (EEO) groups in areas where they demonstrate underrepresentation. In 2001, we realized increases for individuals with disabilities, American Indians/Alaskan Natives and Hispanics.

Official figures provided by the Department of Health and Human Services for the end of fiscal year 2002 indicate that CMS again realized an increase in the workforce representation of Hispanics, up from 3.7 percent in FY 2001 to 4.4 percent in FY 2002. In addition, during fiscal year 2002 CMS successfully increased representation of previously underrepresented EO groups within certain occupational series. Most notably, American Indian females in the 1801 Inspector General/Investigator series advanced from no representation to above parity with the civilian labor force (from 0 percent in FY 2001 to 0.78 percent in FY 2002). Representation for four other groups demonstrated improvement as well, moving out of manifest imbalance during the fiscal year: Hispanic males in the 0107 Health Insurance Specialist series (from 1.29 percent in FY 2001 to 1.33 percent in FY 2002); Asian American females in the 0301 Miscellaneous Administration/Program Administration series (from 0.46 percent in FY 2001 to 1.33 percent in FY 2002); Hispanic females in the 0334/2210 Computer Specialist series (from 1.06 in FY 2001 to 1.47 percent in FY 2002); and white females in the 0501 Financial Administration/Program Administration series (from 21.13 percent in FY 2001 to 27.12 percent in FY 2002).

We continue to utilize various initiatives and hiring authorities to address the underrepresentation of certain EEO groups at CMS. We also reference public sector and private industry reports to replicate successful practices of other Federal agencies in addressing EEO group underrepresentation.

Medicare Savings Programs – In the past CMS focused its efforts on increasing enrollment of dual eligible beneficiaries. Dual eligible beneficiaries are eligible for both the Medicare and the Medicaid programs. The goal to increase awareness about the opportunity to enroll in the Medicare Savings Programs will target the low-income Medicare beneficiary population. Initially this goal will focus on individuals who are eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs. CMS met our target for FY 2002 by establishing a baseline of 11 percent of Medicare beneficiaries that were aware of Medicare Savings Programs. Additionally, targets were established for subsequent years. In FY 2003 we have established a target to increase awareness to 13 percent and 14 percent in FY 2004.

Implement CMS Restructuring Plan – In support of the President's Management Agenda, we have made significant progress toward our FY 2003 goal to achieve greater administrative efficiency through consolidation of administrative functions and a reduction in staffing, and to achieve a more citizen-centered focus through organizational delayering.

In support of our target to consolidate administrative functions, we awarded the Consolidated Information Technology Infrastructure Contract (CITIC) in May 2002 under which CMS has combined multiple information technology support contracts into a consolidated contract. In addition, we have made progress reducing our administrative FTEs using a combination of attrition and re-deployment of incumbents to non-administrative, citizen-centered service positions. We have also completed a reorganization of the human resources (HR) function to facilitate potential consolidation at the Department of Health and Human Services (HHS) level and/or cross servicing with other Operating Divisions within HHS. This reorganization aligned CMS HR functions with consolidation objectives. As of December 2002, 15 of the 16 CMS-identified vertical delayering action items (94 percent) have already been completed. We are confident our efforts will result in meeting our FY 2003 goal of greater administrative efficiency and achieving a more citizen-centered focus.

Performance Goal FAC2-04

Develop and Implement an Information Technology Architecture

Baseline: The CMS use of Information Technology (IT) could not adequately support the future business needs of the Agency. We determined that the development of an improved Information Technology Architecture (ITA) was needed.
FY 2004 Target: Continue maturing the ITA (Enterprise Architecture). Revise and update promulgated policies to ensure continued compliance with Federal and legislative requirements and to address lessons learned from implementation of these promulgated policies.
FY 2003 Target: Continue to develop the ITA (Enterprise Architecture), including further expansion of both breadth and depth using a segmented approach, with specific segments determined as opportunities and needs arise. Complete development and promulgation of remaining IT policies.
FY 2002 Target: Continue development of policies and procedures required for implementation of the HCFA ITA and migration strategy. Complete development and integrate use of standard configuration templates, a.k.a., "System Design Reference Models," with major system development life cycle activities. Monitor ITA conformance as part of the IT Investment Review Process. **Performance:** Goal Met
FY 2001 Target: Develop standard configuration templates for use in major system design efforts. Integrate the ITA conformance criteria into the IT Investment Review Process. **Performance:** Goal Partially Met -- First set of templates near completion, conformance criteria integrated into IT Investment Review Process.
FY 2000 Target: Approve standards and policies for each of the 66 basic service areas identified in the HCFA ITA technical reference model. **Performance:** Goal Met **--** All basic service areas approved, policies addressed as needed.

Discussion: The CMS, as required by the Clinger-Cohen Act of 1996, is developing an integrated, enterprise-wide ITA that is aligned with CMS's strategic business objectives. The ITA will document the relationships between CMS's business and management processes and the technology that supports those processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support CMS's mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS's IT systems. The CMS's Chief Information Officer (CIO) has overall responsibility for the ITA, and has appointed an architect to oversee its development and implementation.

The CMS has developed an IT vision on which the target ITA will be based. Key elements of this vision are:

- a central "core" of well-managed databases;
- modular applications systems accessing the databases; and
- structured interfaces to facilitate access to the data in the core databases.

The CMS has completed the preliminary target architecture and migration strategy. As CMS continues to implement and mature this architecture and migration strategy, the Agency will begin to replace current, system-specific databases with new databases that

have broad applicability across many systems. It will also redesign-antiquated data systems and technology to take advantage of modern, more flexible programming languages. The result will be a systems environment that is more responsive to current and future business demands, less expensive to maintain, and better able to support program operations and policy decision-making.

The CMS has developed an ITA metrics program to measure the implementation and effectiveness of the architecture. It includes two types of metrics: goal-based and process-based. The goal-based metrics relate to 1) ITA maturity; 2) awareness/ compliance relative to the ITA; and 3) organizational impact of the ITA. Selected goal-based metrics will be used for GPRA reporting. The process-based metrics will be used by CMS for internal improvements to the ITA and related processes.

In FY 2002 CMS began its metrics program for GPRA reporting by measuring ITA maturity using the number of standards and preferred IT products that have been approved by the IT Council. Since a baseline of these standards and products has now been established, CMS believes that a sufficient level of ITA maturity relative to standards and products has been reached, thereby making this measurement no longer worthwhile. Instead, we are now measuring the percent of completeness relative to other activities designed to mature and implement the target ITA and migration strategy-activities such as: completion of ITA segments for which subject-specific target architectures and migration strategies have been developed, compliance with the approved criteria used to certify architecture conformance, and use of System Design Reference Models for establishing configurations of platforms and tools for software development projects, development of IT policies and procedures that support the ITA, and integration of models and processes developed as part of the architecture into CMS's day-to-day activities.

Coordination: The CMS is coordinating the ongoing evolution of its architecture and migration strategy with other Department of Health and Human Services (HHS) representatives. This coordination occurs through regular meetings of the HHS CIO Council and its ITA Group.

Data Source(s): Approved standards and preferred IT products are documented in the IT standards profile database, which is accessible through CMS's Intranet. Current work is underway to document all IT policies in a standard manner. We intend to capture all these documented IT policies and associated procedures, templates, guides, etc. in a single repository as part of the Agency's IT Investment Management program (a/k/a "Roadmap"). Also, System Design Reference Models will be integrated into the Roadmap activities.

Verification and Validation: The CIO's Technical Advisory Board verifies and validates that project designs comply with: IT Standards Profile database, the System Design Reference Models, and other Enterprise Architecture conformance criteria.

Performance Goal FAC4-04

Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice

Baseline: Prior to the enactment of the BBA of 1997, SNFs, HHAs, hospital outpatient services, inpatient rehabilitation services and psychiatric hospitals were paid on a cost reimbursement basis (although certain limits applied). Payments to managed care plans were not risk-adjusted (did not reflect variations in per capita costs based on health status of beneficiaries).
FY 2004 Target: Implement PPS system for inpatient psychiatric hospital services**.** A new risk adjustment model for payments to M+COs that incorporates inpatient and ambulatory data will be implemented in CY 2004 and the collection of inpatient and ambulatory data will continue.
FY 2003 Target: Continue design of PPS system for inpatient psychiatric hospital services. Begin the combined collection of both inpatient and ambulatory data for the implementation of an improved Medicare+Choice risk adjustment methodology in CY 2004.
FY 2002 Target: Implement PPS systems for inpatient rehabilitation services during FY 2002. Design PPS systems for psychiatric hospitals. An improved risk adjustment model for payments to Medicare+Choice Organizations (M+CO) will be developed for implementation in CY 2004 and data systems will be implemented to capture both inpatient and ambulatory data. **Performance:** Goal met. The inpatient rehabilitation facilities (IRF) PPS rule was published in the Federal Register on August 7, 2001. IRF PPS was successfully implemented on January 1, 2002. A risk adjustment model for payments to M+COs has been selected that incorporates both inpatient and ambulatory data.
FY 2001 Target: Implement PPS systems for HHA services October 1, 2000. Risk adjusted payments to M+COs will continue to be made based on the PIP-DCG model; and the collection of inpatient data will continue in FY 2001. **Performance:** Goal met. The HHA PPS final rule was effective October 1, 2000.
FY 2000 Target: Implement PPS for hospital outpatient services. Make risk adjusted payments under Medicare+Choice. Publish final PPS regulation for HHA. **Performance:** Goal met. Risk adjusted payments began January 1, 2000 and hospital outpatient department PPS was implemented August 1, 2000. HHA PPS final rule published July 3, 2000.
FY 1999 Target: Establish methodology for SNF PPS and establish risk adjuster methodology for Medicare+Choice. **Performance:** Goal met.

Discussion: The Balanced Budget Act (BBA) of 1997 requires the development of a number of prospective payment systems (PPS) in traditional Medicare and a risk adjustment methodology for payments to Medicare+Choice plans. The categories of providers or services that are to be paid on a prospective basis include skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation hospital services, and services provided in hospital outpatient departments. The Balanced Budget Refinement Act (BBRA) of 1999 requires the development of a PPS for psychiatric hospitals.

Prior to enactment of the BBA, SNFs, HHAs, hospital outpatient services, and inpatient rehabilitation hospital services were paid on a cost reimbursement basis (though certain limits applied). Prior to enactment of the BBRA, psychiatric hospitals also were paid on a cost reimbursement basis. Prospective payment for these services is expected to result in more efficient provision of care, and lower costs to the Medicare program. With regard to payments to Medicare+Choice plans, CMS, the Congressional Budget Office, and numerous researchers have found that, because of the relatively better health of Medicare Health Maintenance Organization (HMO) enrollees, the pre-BBA payment methodology can result in higher costs than fee-for-service Medicare. Based on BBA requirements, the Secretary implemented a risk adjustment methodology, on January 1, 2000, that accounts for variations in per capita costs based on health status. The Medicare, Medicaid and SCHIP Benefits Improvement Protection Act (BIPA) of 2000 further mandates that the risk adjustment methodology starting in 2004 should be based on data from inpatient hospital and ambulatory settings (Section 603).

Coordination: The CMS will work closely with its payment contractors in carrying out this goal.

Data Source(s): Required regulations and/or notices must be published in final in time to implement each provision.

Verification and Validation: We intend to further refine and improve the payment methodologies on a continuous basis. The CMS will use data and studies to determine appropriateness of the payment systems with a view towards continuous refinement.

Performance Goal FAC6-04

Improve CMS's Workforce Planning

Baseline: Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2004.
FY 2004 Target: Update workforce planning data and establish a knowledge and skill level baseline.
FY 2003 Target: Complete development of and implement automated workforce planning modules.
FY 2002 Target: Build and populate an automated workforce planning system based on work roles. - Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role. - Determine future skill and knowledge requirements. **Performance:** Goal met.

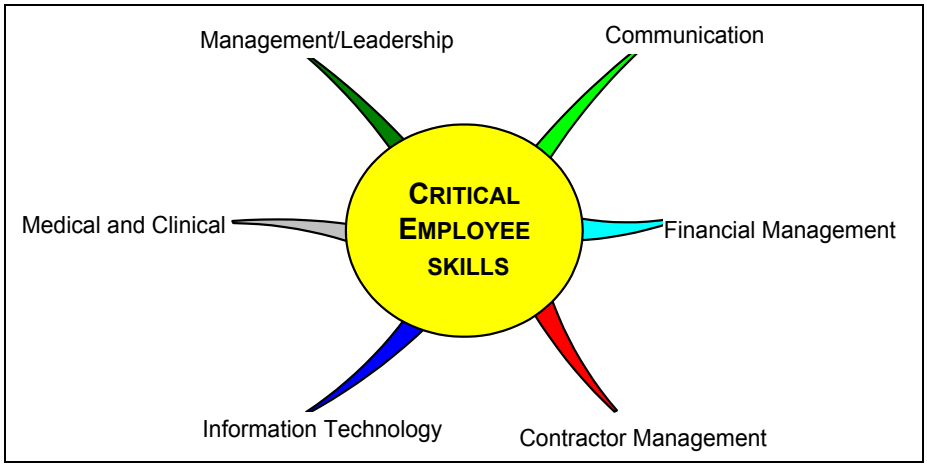
Discussion: Over the years, CMS's programs, structures, and workforce have changed significantly. Today, the organization faces a series of unprecedented business and environmental challenges, which have major implications for CMS's workforce. These challenges demonstrate a need to determine and address gaps in necessary skills and knowledge. The challenges are listed below:

(1) Financial Resources: Increased accountability for programmatic outcomes more closely linked to the budget;
(2) Legislation: Major modifications to our programs as a result of legislation;
(3) Human Resources: Aging workforce and competition for skilled workers;
(4) Agency-wide Restructuring: New skills are required as CMS restructures itself to become more responsive to citizens and other stakeholders.
(5) Increased Stakeholders: Increased program support to partners and stakeholders as beneficiary demographics change and demands grow;
(6) Customers: The CMS's transition from a traditional role as payer and regulator into a broader role as an active market presence;
(7) Technology: Rapid advancements in technology resulting in difficulty obtaining, developing, and retaining technology-related skills; and
(8) Health Care Delivery: Rapid changes in medical practices and technology, requiring new and dynamic methods of oversight and regulation.

Given these challenges, and in accordance with the President's Management Plan, CMS is creating a dynamic workforce planning system to help managers make strategic plans and decisions for hiring/staffing, retention, and human resources development. The CMS workforce planning model will: (1) analyze current and future work; (2) develop a current and future competency framework; (3) identify existing workforce competencies; and (4) conduct an analysis of gaps between current and future requirements and existing workforce skills and knowledge. This four-phase process will be supplemented with

retirement, retention, and demographic analyses. This data serves as the basis for several action plans, including recruitment plans, succession plans, learning plans, and staffing/redeployment plans.

A gap is defined as the level of a skill or knowledge required in carrying out the agency's mission now or in the future, minus the level of that skill or knowledge available in the current workforce. During FY 2000, CMS leadership identified the following six broad competency areas as long-term priority workforce planning needs:



During FY 2001, CMS employees completed a Knowledge and Skills Inventory, identifying their current level of skills and knowledge as well as the levels required in their current positions. Skill and knowledge gaps identified through this one-time data collection initiative were ranked by agency management based on breadth, depth, and criticality for accomplishing CMS's strategic goals. This ranking resulted in the identification of gaps in specific knowledge and skills in each of the six areas listed above, as well as one cross-cutting skill (project management).

In FYs 2002 and 2003, we are implementing strategies to address the gaps in each of the seven knowledge and skill areas. The level of skill or knowledge in these targeted areas will be increased by strategic activities to recruit, develop, retain, and/or redeploy employees. These activities will be evaluated to determine their effectiveness in increasing knowledge or skills. In future years, the automated workforce planning system will be used to determine changes in workforce knowledge and skills.

Design of an intranet-based system to house workforce planning data was initiated in FY 2001. During FY 2002, a prototype system was developed. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. Completion of these modules is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

Coordination: Workforce planning is being done in accordance with guidelines and standards of the Department of Health and Human Services, the Office of Management and Budget, the Office of Personnel Management, and the General Accounting Office. The CMS is working with the American Federation of Government Employees, Local 1923, which represents staff.

C^2 Technologies, Inc. and the American Institutes for Research are developing the design for the automated workforce planning system through the Office of Personnel Management's training management assistance services. Within CMS, the Office of Internal Customer Support is programming the individual modules and coordinating with the Office of Information Services to implement the system.

Data Source(s): Beginning in FY 2003, a series of intranet-based workforce planning modules will house data on the number of full-time equivalents (FTEs) performing each of CMS's business functions and roles, the skills and knowledge required to carry out the functions and roles, and the skills and knowledge of current CMS staff. Employees and managers will be able to access and update information on themselves or their organizations. These modules, when operational, are expected to provide the data for periodic reports on the status of the agency's skill and knowledge requirements.

Verification and Validation: All CMS staff will be expected to provide data on skill and knowledge levels; sampling will not be used. The automated workforce planning modules will allow for managerial validation of skill and knowledge data and employee validation of data provided by managers. The data for the automated system is being collected using standard job analysis and other behavioral science techniques, which include validation procedures.

Performance Goal FAC7-04

Improve CMS's Management Structure

Baseline: Developmental.
FY 2004 Target: Performance Management: Establish a baseline using data from the automated management competency system.
FY 2003 Target: (a) Performance Management: Full implementation of a competency-based performance management (planning and appraisal) program for non-Senior Executive Service (non-SES) managers; **(b)** Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and **(c)** Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Discussion: The CMS faces a number of human resource challenges in the next several years, including the increasing number of managers eligible for retirement. In order to address this challenge, we have had to reevaluate the development and growth of our managers. Like many other Federal agencies, CMS has often chosen managers based upon their technical expertise with little emphasis on their leadership skills. The CMS has initiated a Leadership and Management Development Strategy (LMDS) to build proficiency in the disciplines of leadership and management by developing systems and practices that promote a high standard of leadership throughout the Agency.

The LMDS is based on a set of 5 competencies, encompassing 28 related skills. The five competencies are based on those used by the Office of Personnel Management for members of the Senior Executive Service. The intent is to build proficiency throughout the Agency in the disciplines of management and leadership by developing systems and practices that promote a high standard of leadership that is both results-oriented and customer-focused. These proficiencies will enable CMS managers to become better stewards of the programs entrusted to the Agency by the public. The LMDS addresses a wide range of activities, including performance management and awards and recognition, which comprise our FY 2003 targets, along with recruitment and selection and continuous learning, which are efforts that are already in progress.

Recruitment and Selection

Many Government managers are often selected on the basis of their personal technical expertise, without emphasis on demonstrated leadership skills. Novice managers who do not receive timely training and mentoring for their new roles often continue to function as technical leads with a few added administrative duties.

In 1999, CMS introduced a new process, on a pilot basis, for recruiting and selecting managers based on the five managerial competencies—managing change, leading people, producing results, managing resources, and partnering/building coalitions. Working from the list of 28 competency-related Knowledge Skills and Abilities (KSAs), selecting officials chose the KSAs that were most important for the position being filled, with all five managerial competencies being represented, in addition to technical KSAs, specific to a CMS program or function. In this way, a balance was maintained between the

desired technical and managerial selection criteria. Full implementation of the competency-based recruitment and selection process for non-SES managers was fully implemented effective March 4, 2002.

Performance Management

Performance management (planning and appraisal) programs fulfill five organizational purposes: 1) linking individual performance to the organization's mission and objectives; 2) defining what constitutes acceptable performance; 3) measuring and evaluating individual performance; 4) relaying information about current performance back to individuals to shape their future performance; and 5) providing information to related management systems (such as compensation or succession planning).

The CMS is working to introduce a performance planning and appraisal program for non-SES managers that will encourage managers to discuss, develop and apply the managerial competencies. One of our targets is to have this performance management program fully developed in FY 2003.

In line with the Performance Management Program for managers (i.e. appraisal and awards and recognition systems), in FY 2003, CMS is developing an automated system (form and database) that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports. This information will allow us to determine the management competencies most used in CMS and to track ratings from year to year. The theory is if the human resources processes consistently support these core management competencies; that is, we recruit and select based on these competencies, managers are rated against these competencies, our management training focuses on these competencies and managers are rewarded for demonstrating these competencies, the current culture will change and CMS managers will become better leaders.

We will gather baseline data from the automated system in FY 2004 to begin measuring improvement in the leadership competencies.

Awards and Recognition

Any attempt to implement a competency-based approach to management must recognize all competencies, both programmatic and managerial. To support competency-based recruitment and hiring and performance management, CMS will develop an awards and recognition program for non-SES managers in FY 2003.

Continuous Learning

Using a managerial competency-based model for management is the foundation for improved recruitment and selection, performance management, and awards and recognition for CMS managers.

To that end, CMS has identified a core set of classroom learning opportunities that will help managers, both new and established, acquire and become proficient in basic management skills. The initial set of courses was first offered in FY 2001, and we

continue to identify additional courses and other learning opportunities. In FY 2002 we revised requirements to make the core management learning opportunities mandatory for probationary managers and to make a reasonable number of continuing management education classes mandatory in each year after completion of probation for all managers.

Coordination: The goal to improve CMS's management structure is being conducted in accordance with a modified approach used by the Office of Personnel Management for members of the Senior Executive Service. All activities in this regard are undertaken with the concurrence of the LMDS Advisory Panel and the CMS Leadership Development and Recognition Board.

Data Source(s): Developmental. In FY 2003, CMS is developing an automated system that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports.

Verification and Validation: Developmental. The selected CMS managerial competencies were validated in the Agency under contract with Wilson Learning. All management evaluations, including competency information to be entered into the automated system, are reviewed at the Office/Center Director and Regional Administrator level through the management reporting feature of the automated system.

Performance Goal FAC8-04

Strengthen and Maintain Diversity at all Levels of CMS

Baseline: Comparing the CMS Workforce with the National Civilian Labor Force (CLF), in FY 2000, there were Equal Employment Opportunity (EEO) groups that exhibited manifest imbalance in the CMS workforce.
FY 2004 Target: Increase the representation of EEO groups in areas where they demonstrate underrepresentation.
FY 2003 Target: Increase the representation of EEO groups in areas where they demonstrate underrepresentation.

Discussion: Workforce diversity has evolved from sound public policy to a strategic business imperative. Federal diversity initiatives have historically focused on equal employment opportunity (EEO) and affirmative employment. The Federal Government must now broaden its view of diversity. We must embrace the business, cultural, and demographic dimensions of diversity as well as the legal dimension. Focusing on diversity and looking for more ways to be a truly inclusive organization--one that makes full use of the contributions of all employees--is not just a nice idea; it is good business sense that yields greater productivity and competitive advantage. Diversity management programs are recognized as being a critical link in achieving the Agency's specific mission or business needs, relative to employees, customers, suppliers, and other stakeholders. This is the business case for valuing diversity.

The business case for diversity has two significant elements. First, the labor market has become increasingly competitive. We must use every available source of candidates to ensure that we have the high-quality workforce needed to deliver our mission to the American public. It is an intangible asset for an organization to have a good public perception. Being recognized as an organization that values diversity contributes to a positive image which in turn will attract the best and the brightest employees. As the value of diversity continues to grow in the business community and elsewhere, recruiting and retaining talented employees who are diverse is becoming even more important to an organization's success. Second, the changing demographics of America mean that the public served by CMS is also changing. When we recruit and retain an inclusive workforce--one that looks like the America we serve--and when individual differences are respected, appreciated, and valued, diversity becomes an organizational strength that contributes to achieving results. A byproduct of capitalizing on differences is creativity. Historically, some of the most creative periods in civilization have emerged when people of different backgrounds had contact. Employees from varied backgrounds can bring different perspectives, ideas and solutions to use in strategic planning, problem solving, and decision making. It enables us to better serve the taxpayer by reflecting the customers and communities we serve.

All Federal agencies strive for "parity"[1] with the Civilian Labor Force. By doing so, we ensure the diversity we seek, since the Civilian Labor Force is comprised of persons

[1] Parity exists when an EEO group's Agency workforce representation is equal to the Civilian Labor Force.

age 16 and over, excluding those in the armed Forces, who are employed or seeking employment.

Workforce diversity is characterized along a continuum of 1) parity, 2) near parity, 3) manifest imbalance and 4) conspicuous absence.[2] On the road to achieving parity in its workforce, CMS must first reduce the manifest imbalances that currently exist.

Federal agencies are required by regulation to monitor the representation of all EEO groups each year and to report Agency activities and accomplishments to the Equal Employment Opportunity Commission and the Office of Personnel Management (OPM). Strategies that will bring improvement include: communicating the Agency leadership's strong commitment to diversity, workforce planning, conducting effective outreach and recruitment, utilizing hiring flexibilities, maintaining a supportive work environment, providing development and training opportunities (upward mobility programs), monitoring activities and making adjustments as needed, establishing accountability, reward success and continuously educate and communicate the value of diversity.

Coordination: Department of Health and Human Services; Equal Employment Opportunity Commission; OPM (Federal Equal Opportunity Recruitment Program (FEORP)); Department of Labor, Office of Disability Employment Policy; State Vocational Rehabilitation Agencies; national colleges and universities (including Historically Black Colleges and Universities, Hispanic Serving Institutions, and Tribal Colleges and Universities); Federal Asian Pacific American Council; Organization of Chinese Americans; National IMAGE; League of United Latin American Citizens, National Council of LaRaza; National Hispanic Leadership Conference; National Society of Hispanic MBAs; Blacks in Government; National Association for the Advancement of Colored People; National Congress of American Indians; and Association of American Health Plans, Minority Management Development Program.

Data Source(s):

- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 1990 official decennial census figures[3]
- The 1990 official decennial census figures
- OPM's Central Personnel Data File (updated every pay period)
- HHS' Workforce Inventory Profile System (WIPS) (updated every pay period)
- The CMS Workforce Profiles (prepared using (WIPS)

Verification and Validation:

- 1990 Civilian Labor Force data - Validated and verified by the Census Bureau

[2] Conspicuous Absence occurs when an EEO group's Agency workforce representation is between 0 and 20% of the Civilian Labor Force.

[3] EEOC Office of Public Sector Programs requires agencies to use current, official Census Bureau Civilian Labor Force data to calculate under-representation indices. The Census Bureau is in the process of analyzing 2000 census data by occupation category and code. The Census Bureau estimates that verification and validation will be completed in 2003 and that official figures will be available in late 2003.

- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 1990 official decennial census figures - Validated and verified by OPM. These are the standard government-wide statistics.
- Central Personnel Data File - Validated and verified by OPM.
- HHS' Workforce Inventory Profile System (WIPS) - Validated and verified by HHS.
- The CMS Workforce Profiles - Validated and verified by CMS.

Performance Goal FAC9-04

Increase Awareness of the Opportunity to Enroll in the Medicare Savings Programs

Baseline: In FY 2002, 11 percent of Medicare beneficiaries were aware of Medicare Savings Programs.
FY 2004 Target: Increase awareness of Medicare Savings Programs to 14 percent.
FY 2003 Target: Increase awareness of Medicare Savings Programs to 13 percent.
FY 2002 Target: Develop baseline and set future targets. **Performance**: Goal met

Discussion: Although Medicare provides beneficiaries with a basic set of health benefits, the beneficiaries are still required to pay a significant amount out-of-pocket for premiums, deductibles and co-insurance. These costs can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance. This performance goal will seek to increase awareness of State programs that can assist low-income Medicare beneficiaries with their Medicare cost-sharing expenses.

The Medicare Savings Programs enacted to help Medicare beneficiaries with their cost-sharing expenses include, among others, Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), and Qualifying Individual (QI).

In the initial years of this endeavor, we will emphasize awareness to individuals who are eligible for the QMB and SLMB programs. These programs were enacted to help low-income Medicare beneficiaries with their Medicare cost-sharing expenses. States are required to pay for the premiums, deductibles, and cost sharing for QMBs. For SLMBs, they are required to pay for the Part B premium. Despite the existence of these programs, a substantial proportion of individuals eligible for these programs are not enrolled (e.g. two recent studies estimated non-participation rates for QMB to range from 40-60 percent).

Since enactment of the QMB and SLMB provisions, CMS has undertaken a number of outreach initiatives directed at providing awareness of the programs. These efforts include development of brochures for targeted populations such as: African American, Hispanic, Asian American Pacific Islander, American Indian/Alaskan Native, caregivers, and the disabled. These brochures are available on the Medicare.gov website. Information regarding the Medicare Savings Programs is available in CMS publications such as: the *Medicare & You* handbook (which includes information about the programs, and provides a toll-free telephone number for beneficiaries to call for more information) and the Guide to Health Insurance for People with Medicare. Additionally, the Regional Education About Choices in Health (REACH) Campaign through community-based outreach activities and regional materials will continue to educate Medicare beneficiaries

on the Medicare Savings Programs. The State Health Insurance Assistance Programs (SHIPS) provide assistance through individual counseling and group education activities to educate Medicare beneficiaries about the programs. The SHIPS are kept abreast of all activities related to the Medicare Savings Programs. In addition, CMS has partnered with the Social Security Administration (SSA) and provided state-specific language that was used in letters to potentially eligible Medicare beneficiaries who appeared to meet the income criteria of the QMB/SLMB and QI-1 programs. CMS also provides alerts and other information on these mailings to Regional Offices and to SHIPS. The mailing targeted 16.5 million Medicare beneficiaries. SSA conducted the mailing based on a mandate under section 1144 of the Social Security Act. SSA will conduct annual mailings.

The CMS also has provided interested States with identifying information about newly eligible Medicare beneficiaries who are potential candidates for the State programs. In order to achieve our goal we are working with States, the advocacy community, and other interested parties to develop a comprehensive strategy to increase awareness about Medicare Savings Programs.

Coordination: The CMS has conducted a number of activities in the area of outreach in partnership with other Federal agencies, States, providers, and community organizations. These activities included: direct mailings to beneficiaries and grants to State Health Insurance Assistance Programs (SHIPs), States, ombudsman and information intermediaries for outreach. The CMS will continue to use various channels of communications and information intermediaries to increase Medicare beneficiary awareness about the opportunity to enroll in programs that might be able to assist them with their Medicare cost-sharing expenses. Outreach strategies will only be able to be fully realized through the continuation of the partnerships that have been formed with other Federal agencies, such as the Social Security Administration and the Health Resources and Services Administration.

Data Source(s): The primary source of data on beneficiary awareness of the Medicare Savings Programs will be the Medicare Current Beneficiary Survey (MCBS). The CMS will track progress for this goal using MCBS data. The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. The MCBS includes questions that ask beneficiaries about their awareness of programs that are open to seniors and persons with disabilities who have limited financial resources and need help paying Medicare-related costs. The measure will only include low-income beneficiaries.

The questions are in a "yes," "no," and "don't know" format. For ethical reasons, after asking questions, MCBS interviewers will make the correct answers to the questions available to the respondents (beneficiaries cannot inadvertently be left with any misperceptions about the program). Therefore, the act of surveying these respondents would confound subsequent measurement of their awareness of the program features.

Sampled beneficiaries remain in the MCBS for 3 years and then rotate out of the survey. Thus, each year about one-third of the overall MCBS sample is new and two-thirds are returning. To avoid instrumentation bias, the measure will only include new MCBS members. This new part of the MCBS sample is itself nationally representative of the Medicare population.

Verification and Validation: All data from the MCBS are carefully edited and cleaned prior to the creation of analytic data files. Sample weights will be prepared that allow adjustments to survey estimates to account for differential probabilities of selection in the MCBS sample, under-coverage, and differential patterns of survey non-response. Statistical precision will be calculated and presented with the estimates.

Performance Goal FAC10-04

Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization

Baseline: CMS FY 2002 FTE Ceiling of 4632 and up to five management levels in the organization as of January 01, 2002.
FY 2004 Target: Developmental
FY 2003 Target: 1. Achieve greater administrative efficiency through consolidation of administrative functions and enhance the delivery of citizen-centered services by developing strategies that will enable the reduction of administrative FTE by 93 without substantially reducing the level of administrative services necessary to maintain CMS's operational efficiency. 2. Achieve a more citizen-centered focus through organizational de-layering, from five layers to four, in 16 CMS components.

Discussion: In support of the President's Management Agenda, the Secretary directed the Department of Health and Human Services (DHHS) to consolidate administrative functions for all Operating Divisions (OPDIV) to achieve greater administrative efficiency. The resultant improvements in administrative efficiency will enable OPDIVs to significantly reduce the FTE required to perform administrative functions, and will thus allow OPDIVs to transfer these FTE resources into positions responsible for the direct provision of citizen-centered services. Along these lines, by the end of FY 2003, CMS will reduce administrative (e.g., human resources, facilities management, budget and finance, information technology (IT), procurement, and grants management) FTE usage by 93 (from the projected FY 2002 usage). These reductions will be achieved using either attrition (with vacant FTE transferred to direct citizen-centered service positions) or the re-deployment of incumbents into direct citizen-centered service positions. Voluntary Early Retirement Authority (VERA) was approved for CMS in August 2002 to assist in reducing the targeted administrative function FTEs via attrition. As of December 2002, some 40 individuals have filed a "statement of interest" relevant to VERA, and 11 individuals have filed actual VERA retirement applications. CMS requested and was granted a 90-day extension (through September 2003) in this authority, which we believe could result in a further reduction of some 5-10 administrative FTE and a corresponding re-deployment of staff to line positions.

In order to achieve the administrative efficiencies necessary to allow for reduction of 23 FTEs in the human resources (HR) area without compromising requisite levels of internal administrative support, CMS is working closely with DHHS to maximize consolidation of HR functions and intra-Departmental cross-servicing arrangements to establish significantly improved "economies of scale." The CMS is also exploring enhancements to its HR automation environment to help facilitate HR FTE reduction. We implemented a major restructuring of the CMS Human Resources Management Group in June 2002 to separate the HR strategic consulting function from the classification and staffing operations in order to position ourselves to better evaluate competitive sourcing, shared servicing, and automation options. Again, we believe that this initiative will enable us to better absorb the loss of administrative FTE targeted for the HR function.

In addition to the elimination of the 93 FTE addressed above, CMS is supporting the consolidation of public affairs and legislative functions within DHHS, resulting in a transfer of 63 full-time equivalents (FTEs) from CMS to the Office of the Secretary. A final effective date has not been set.

The CMS developed and submitted to DHHS a Hiring Plan for fiscal year 2002, and a Restructuring Action Plan to achieve the restructuring objectives for administrative efficiency and de-layering. CMS is in the process of developing its final FY 2003 hiring plan, and this plan will continue to reflect strong adherence to restructuring and de-layering principles. Through these plans, we hope to further our goal of creating a more citizen-centered, diverse, high quality workforce at all levels of the Agency. Further restructuring activities for FY 2004 will be targeted pending additional guidance.

In general, all CMS administrative functions, such as budget and financial management, human resource management, public affairs, and legislative affairs are already consolidated at the OPDIV level, except where sound business reasons dictate otherwise. Many of the specific steps detailed in the Action Plan refine current business operations of consolidated functions to improve efficiency and service delivery. For example, where financial operations occur outside the direct line authority of the Chief Financial Officer (CFO), the Agency's Financial Management and Investment Board (FMIB), which reports directly to the Deputy Administrator and Chief Operating Officer, has financial oversight responsibility. In the area of IT, CMS awarded the Consolidated Information Technology Infrastructure Contract (CITIC) in May 2002. Under CITIC, CMS has combined multiple IT infrastructure support contracts (data center, network services, telecommunications, etc.) into a consolidated contract managed by the Office of Information Services.

We have identified all organizations in which we have more than the target level of four management layers for the Agency, and have developed plans and organization charts for achieving the goal of four management levels. De-layering efforts for 15 of the 16 organizations identified under this initiative have already been completed, and the reorganization package for the final identified organization is currently being reviewed. We anticipate that this final targeted organizational effort will be successfully concluded shortly. Moreover, we have identified and eliminated many of the double deputies that presently exist in the Agency. We are confident this will help us achieve a more citizen-centered focus and will complement many of the other citizen-centered initiatives already in place within CMS.

The number of FTEs reduced through streamlining/consolidation activities is currently being measured. The CMS organization structure will be used to determine the target of four management levels. We will compare the difference between CMS’s FY 2002 baseline FTE ceiling of 4632 and the number of management levels in the organization as of January 1, 2002 to the actual levels achieved for both of these data sources by the end of FY 2003.

Coordination: The goal to implement a CMS Restructuring Plan to create a more citizen-centered organization is being coordinated with the Office of the Assistant Secretary for Administration and Management.

Data Source(s): The CMS Employment Status Report, which tracks FTE ceiling, gains and losses, will be used to measure FTE reduction. The CMS Organizational charts will determine the target for organizational de-layering.

Verification and Validation: Internal checks of the information are regularly performed.

Research, Demonstration, and Evaluation

Research, Demonstration, and Evaluation	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	**$138.3 M**	**$117.2 M**	**$28.4 M**	**$63.4 M**

The Research, Demonstration and Evaluation program supports CMS's role as a beneficiary-centered purchaser of the highest quality health care at the lowest possible cost. The CMS performs, coordinates, and supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of CMS's programs on its beneficiaries, providers, States, and other customers. This role requires the development, implementation and evaluation of a variety of innovative, new demonstration projects as well as expanded efforts to evaluate the effectiveness of CMS's current programs. These research responsibilities include evaluations of the Medicare and Medicaid programs and the State Children's Health Insurance Program.

Other representative goals that are related to this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-04)
- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice (FAC4-04)

Performance Goal	Targets	Actual Performance	Ref.
Assess the relationship between CMS research investments and program improvements	**FY 04:** Conduct internal assessment **FY 03:** Conduct internal assessment **FY 02:** Repeat internal and external assessments **FY 01:** Repeat internal assessment; conduct initial external review **FY 00:** Conduct internal and external assessments **FY 99:** Develop goal for FY 2000	**FY 04:** **FY 03:** **FY 02:** Internal assessment and external review completed (Goal met) **FY 01:** Internal assessment and external review completed (Goal met) **FY 00:** First internal assessment conducted; External review delayed **FY 99:** Goal developed (Goal met)	R1 See FY 03 Revised Final

Performance Results Discussion

Research - Assessing the impact of research and demonstration activities is challenging. In many cases the anticipated effects are long-term outcomes. In addition, proving a direct correlation between a research intervention and a given result can be very difficult, particularly in the field of health care where multiple variables can cloud the analysis.

We met our FY 2002 target by conducting internal and external assessments of CMS research. The external reviewers echoed the overall conclusions of the FY 2001 external reviewers in finding the internal assessments to be a careful and thoughtful review of CMS research. Overall, the reviewers found our characterization of the accomplishments and limitations in each research area to be accurate. They found the internal assessment to be useful for understanding how CMS has approached its research responsibilities and for assessing future research needs. The FY 2002 external reviewers did, however, feel strongly that annual assessments are too frequent to accurately assess the results of multiyear research agendas.

Based on the recommendations made by the external reviewers and CMS research leadership, we plan to continue annual internal assessments and to further integrate them with our work planning and budgeting processes. However, we will move to a 3-year cycle for the external assessments and conduct our next one in FY 2005.

For FY 2003, we plan to perform an internal assessment that covers the events of the past year - both project accomplishments and modifications in research plans in response to new and evolving priorities. We will also take the recommendations of past external reviewers into account as we refine our internal assessment process. We will report on the status of our FY 2003 internal assessment by the end of FY 2003.

Performance Goal R1-04

Assess the Relationship between CMS Research Investments and Program Improvements

FY 2004 Target: Conduct internal assessment.
FY 2003 Target: Conduct internal assessment.
FY 2002 Target: Repeat internal and external assessments. **Performance:** Goal met – internal assessment and external review completed.
FY 2001 Target: Repeat internal assessment. Conduct initial external review. **Performance:** Goal met – internal assessment and external review completed.
FY 2000 Target: The baseline internal performance assessment will be conducted between August 1999 and February 2000. For this initial year, the external review of the internal assessment will be carried out between February and August 2000. **Performance**: Goal partially met - internal assessment conducted; first external review delayed.
FY 1999 Target: Develop a goal. **Performance:** Goal met.

Discussion: The purpose of CMS's research program is to provide CMS and the health care policy community with objective analyses and information to foster improvement in CMS programs and to guide the Agency in its future direction. The CMS's research and development (R&D) functions are to develop, test and implement new health care financing policies and to monitor and evaluate the impact of CMS's programs on its beneficiaries, providers, States, and other customers and partners. In addition, CMS's research program produces a body of knowledge that is used by Congress, the Executive Branch, and the States to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and State Children's Health Insurance programs.

A regular systematic review and assessment of CMS's research program is important to ensure that CMS's beneficiaries obtain maximum benefits from R&D spending. The CMS's performance on this goal is measured using a formal annual internal assessment that is reviewed and evaluated by external experts. The internal assessment is dovetailed with the development of the 2-year research plan and budget, which involves consultation with all CMS components regarding their research needs. In turn, each CMS component with projects in the research budget will be responsible for performing the internal assessment of their projects.

We have found that annual internal assessments are a useful way to monitor our ongoing R&D activities. However, the external review benefits from a broad multiyear perspective, and we believe that the external process can more effectively be conducted every 3 years. Therefore, beginning in FY 2003, we will continue to conduct internal assessments on an annual basis, but we will only perform external assessments every

three years. After the FY 2002 external assessment, the next external assessment will not occur until FY 2005.

Coordination: Coordination of CMS R&D activities with other Federal and State organizations, non-profit research foundations, colleges and universities, private research firms, research components of trade organizations, and advocacy groups takes place regularly on a variety of levels. The CMS staff regularly participates in the annual conferences of groups such as the American Public Health Association and the Association for Health Services Research, as well as professional meetings of social science associations. These contacts are important in defining CMS's R&D agenda, avoiding duplication of effort, stimulating research on CMS issues by researchers outside of CMS, and generally increasing the productivity of CMS R&D.

Data Source(s): The CMS developed an assessment report for evaluating its research efforts. Data sources used for this report include the CMS R&D Plan, legislation that mandates CMS research activities, and other documents produced under CMS research, demonstration, and evaluation projects.

Verification and Validation: The application of research effectiveness criteria combines internal self-assessment and review by external experts. All CMS components responsible for research and demonstration projects are involved in the self-assessment process. The external experts are drawn from highly credible researchers familiar with both CMS programs and the national scope of health care research.

Revitalization Plan

Revitalization Plan	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	**N/A**	**N/A**	**N/A**	**$65.0 M**

The CMS Revitalization Plan is a new, multi-year investment that will fund fundamental infrastructure improvements, modernize systems and operations, and bring Medicare and Medicaid operations into the modern era.

The first step in this revitalization process focuses on four major challenges involving information technology (IT). Revitalization Plan activities scheduled for FY 2004 include mitigating systems security risks at CMS and our Medicare contractors, modernizing Medicare fee-for-service claims processing, modernizing several databases vital to Medicare and Medicaid program operations, and modernizing CMS IT infrastructure to support a secure e-government/e-commerce environment.

Other representative goal(s) that relate to this budget category but are not listed in the chart are:

- Increase the Use of Electronic Commerce/Standards in Medicare (MO3-04)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-04)
- Improve Beneficiary Understanding of Basic Features of the Medicare Program (MO9-04)

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS's Information Systems Security:	**FY04:** --Achieve zero material weaknesses --Accredit security plans --Fund corrective action plans for Medicare contractors --Publish security standards in CMS ITA --Establish policies for automation of paper-based processes		RP1 Formerly FAC3 See FY 03 Revised Final
	FY 03: -- Eliminate all material weaknesses -- Implement access control management system	**FY 03:**	**2**
	FY 02: -- Eliminate all material weaknesses -- Evaluate Medicare contractors' security profile and apply baseline to CMS's business partners -- Implement intrusion detection & response procedure	**FY 02:** --Expect to meet (Results avail Jan 2003) **--**Evaluation complete (Goal met) **--**Implemented April 02 (Goal met)	
	FY 01: -- Eliminate all material weaknesses -- Increase percent of employees receiving security training to 95% -- Increase proportion of Medicare contractor sites receiving security review	**FY 01:** -- One weakness (Goal not met) -- 20% CBT delayed (Goal not met) --One-third (Goal met)	
	FY 00: -- Eliminate all material weaknesses	**FY 00:** **--** one weakness (Goal not met) **FY 99:** two weaknesses **FY 97:** five weaknesses **(Baseline)**	

Performance Results Discussion

Information Systems Security – The CMS has created a goal to improve its information systems security policies and practices enterprise-wide. Evaluations have been completed on high-risk Medicare contractors and CMS has begun funding projects to close the gaps between the security profiles and core security requirements. A corrective action plan was created to address the material weakness of the Electronic Data Process (EDP) portion cited in CMS's FY 2001 CFO report for both Central Office and Medicare contractor systems. The 2002 CFO audit results will not be available until January 2003 however; the target is expected to be met. A computer-based training (CBT) package was deployed to all personnel to increase the number of employees receiving training. This program was prolonged due to a major rewrite to

include section 508 of the Americans with Disabilities Act, therefore the FY 2001 target to have 95 percent of CMS employees receive security awareness training carried over into 2002. In April 2002, CMS implemented an intrusion detection capability and incident response procedure documentation was prepared and distributed for comment. The CMS has reviewed the comments and prepared a draft final document, which was submitted to CMS's CIO Technical Advisory Board (CTAB) for their review.

We are confident the program will result in continued improvement in the security posture of CMS and are optimistic that future goals will be met.

Performance Goal RP1-04

Improve CMS's Information Systems Security

Baseline: The 1997 OIG electronic data processing (EDP) audit for CMS's Central Office showed one material weakness and 31 reportable conditions, and four material weaknesses and 102 reportable conditions for Medicare contractor systems. In Central Office, there was a material weakness in the control of access to production data. In the contractor area, there was one material weakness in physical access and three in the control of local modifications or overrides to shared system applications and edits programs. Reportable conditions were found in all seven categories of evaluation.
FY 2004: Achieve zero material weaknesses in the CFO EDP Controls Audit. Security plans accredited for CMS General Support Systems. Fund corrective actions at Medicare contractors to the extent of available resources. Implement host-based IDS on mission-critical CMS systems. Minimum security standards for CMS systems are formally published in the CMS IT Architecture. Establish digital signature and encryption policies to enable automation of paper-based administrative processes.
FY 2003: Achieve zero material weaknesses in the EDP portion of the FY 2003 CFO audit. Implement improved access control management system.
FY 2002: Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Evaluate the highest risk Medicare contractors' security profiles against a comprehensive baseline of security requirements. Begin to apply the comprehensive baseline of security requirements to CMS's business partners. Implement an intrusion detection capability and document an incident response procedure. **Performance:** Goal pending CFO report.
FY 2001: Achieve zero material weaknesses in EDP portion of the FY 2001 CFO audits. In addition, 95 percent of CMS employees will receive security awareness training; and CMS will complete site security reviews for its Medicare payment contractors. (Each contractor will be reviewed once every 3 years.) **Performance:** Goal not met, one material weakness.
FY 2000: Achieve, for both Central Office and Medicare payment contractor systems, zero material weaknesses in the EDP portion of the FY 2000 CFO audit. **Performance:** Goal not met, one material weakness being explored for closure.

Discussion: As CMS moves further into on-line activity, with increased business partners and technological complexity, the protection of confidential information becomes even more critical. The CMS is fully committed to fulfilling its stewardship responsibilities for the information contained in its data systems and transported across its networks.

In the FY 2001 CFO audit, one material weakness was cited. A corrective action plan was created to address this weakness. Under this plan, a mitigating protocol establishing strict controls over local program changes has been created and field-tested. Beginning in 2002, all data centers running Fiscal Intermediary Standard System (FISS) are subject to review using this protocol. The results of the 2002 CFO audit will not be available early 2003.

The CMS developed a multiple year Medicare Contractor Systems Security Plan for FY 2000. This plan requires contractors to have comprehensive security programs covering administrative, physical and technical safeguards based on a current specific set of core requirements, which include security requirements from OMB, GAO, IRS, Presidential Decision Directives (PDD) 63, and HIPAA.

In FY 2002, CMS completed evaluation of the highest risk Medicare contractors' security profiles against the comprehensive baseline of security requirements. Medicare contractors proposed 1,602 needed safeguards in the 2001 CAST security assessment to comply with CMS's baseline security requirements at a cost of $70 million. In March 2002, CMS funded 642 proposed safeguards at a cost of $4.8 million. In August 2002, CMS funded an additional 174 safeguards and 53 system security plans at a cost of $9.7 million. Many of these safeguards have recurring costs that will be absorbed in the regular Medicare contractor budget. The CMS operating budget for FY2003 does not allocate funds to Medicare contractors to implement systems security requirements because of the funding provided in August 2002.

The CMS's strategy is to complete the evaluation process of all other Medicare contractors and to close the gaps identified. The evaluation process will be accomplished through Statement of Auditing Standards (SAS70) and Chief Financial Officers (CFO) reviews and CMS will then begin a comprehensive evaluation of the effectiveness of all contractor security activities.

The CMS also implemented an intrusion detection capability on the first of three ingress points on the network in April 2002. Incident response procedure documentation was prepared and distributed for comment. The CMS has reviewed the comments and prepared a draft final document, which was submitted to CMS's CIO Technical Advisory Board (CTAB) on September 25, 2002, for their review.

In accomplishing the goals outlined above, CMS is ensuring that we are in compliance with the Government Information Security Reform Act (GISRA). GISRA underscores the activities of the agency.

Coordination: The scope of enterprise systems security spans across the data, applications, and infrastructure services supporting all of CMS's business areas. We have formulated a systems security management framework to achieve the systems security improvement goals systematically. The CMS's Office of Information Services will work with CMS internal/external business managers and data owners to assess current security posture, establish target positions, and formulate transition plans.

Data Source(s): The CMS will retain training documents, to include computerized documentation in support of Computer Based Training (CBT) for all CMS users, and copies of public service announcements. For the remaining portions of the target, OIG audit findings, CMS's review findings and associated corrective actions tracking database (under development) will be the primary data sources for the CFO audit portion of this goal.

Verification and Validation: Attendance records will be retained for security training and may be validated. Validation may be performed through checks of sign-in-sheets. Audit and review findings are reviewed by information security personnel and verified by systems owners.

PART III – APPENDIX TO THE PERFORMANCE PLAN

A.1 Linkage to HHS and CMS Strategic Plans

A key concept underpinning the GPRA law is the close linkage of an agency's strategic plan, performance plan, and its budget. The next few pages illustrate the linkages of the FY 2004 Annual Performance Plan goals to the draft FY 2003-2008 HHS Strategic Plan and the new CMS Strategic Plan.

LINK OF FY 2004 CMS PERFORMANCE GOALS AND THE DRAFT FY 2003-2008 HHS STRATEGIC PLAN

FY 2004 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Medicare Benefits								
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services			✓		✓			
Improved Medicare's Administration of the Beneficiary Appeals Process					✓			
Quality of Care: Quality Improvement Organizations								
Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal	✓		✓					
Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram	✓		✓					
Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams	✓				✓			
Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection	✓				✓			
Quality of Care: Survey & Certification								
Decrease the Prevalence of Restraints in Nursing Homes			✓		✓			
Decrease the Prevalence of Pressure Ulcers in Nursing Homes			✓		✓			
Improve the Management of the Survey and Certification Budget Development and Execution Process					✓			✓
Grants to States for Medicaid/Medicaid Agencies								
Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized	✓						✓	
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates								✓
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP)					✓			

FY 2004 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
State Children's Health Insurance Program								
Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid			✓					
Clinical Laboratory Improvement Amendments (CLIA)								
Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver					✓			
Medicare Integrity Program								
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Services Program			✓					✓
Assess Program Integrity Customer Service			✓					✓
Improve the Provider Enrollment Process			✓					✓
Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Exchange Agreements with Insurers or Employers								✓
Reduce the Medicare Contractor Error Rate			✓					✓
Improve the Medicare Provider Compliance Rate			✓					✓
Medicare Operations								
Improve Beneficiary Telephone Customer Service			✓					
Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements			✓					
Increase the Use of Electronic Commerce/Standards in Medicare			✓		✓			
Maintain CMS's Improved Rating on Financial Statements								✓
Improve CMS Oversight of Medicare Fee-for-Service Contractors					✓			✓
Increase Referral of Eligible Delinquent Debt for Cross Servicing								✓
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries			✓		✓			
Improve Beneficiary Understanding of Basic Features of the Medicare Program			✓		✓			
Federal Administrative Costs								
Develop and Implement an IT Architecture					✓			
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice			✓					✓
Improve CMS's Workforce Planning								✓
Improve CMS's Management Structure								✓
Strengthen and Maintain Diversity at all Levels of CMS								✓
Increase Awareness About the Opportunity to Enroll in the Medicare Savings Programs			✓					
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization								✓
Research, Demonstration, and Evaluation								
Assess the Relationship between CMS Research Investments and Program Improvements				✓				

FY 2004 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Revitalization Plan								
Improved CMS's Information Systems Security		✓						

* DHHS Strategic Goals
Goal 1 – Reduce the major threats to the health and well-being of Americans.
Goal 2 – Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges
Goal 3 – Increase the percentage of the Nation's children and adults who have access to regular health care services and expand consumer choices
Goal 4 – Enhance the capacity and productivity of the Nation's health science research enterprise
Goal 5 – Improve the quality of health care services
Goal 6 – Improve the economic and social well-being of individuals, families, and communities, especially those most in need
Goal 7 – Improve the stability and healthy development of our Nation's children and youth
Goal 8 – Achieve excellence in management practices

Linking CMS's FY 2004 Performance Goals to CMS's Strategic Goals*

Protect and improve beneficiary health and satisfaction.

- Improve satisfaction of Medicare beneficiaries with health care services they receive.
- Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal.
- Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram.
- Increase the percentage of Medicaid two-year-old children who are fully immunized.
- Decrease the number of uninsured children by working with States to implement SCHIP & by enrolling children in Medicaid.
- Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.
- Protect the health of Medicare beneficiaries by optimizing the timing of administration of antibiotics to reduce the frequency of surgical site infection.
- Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP).
- Decrease the prevalence of restraints in nursing homes.
- Decrease the prevalence of pressure ulcers in nursing homes.

Foster appropriate and predictable payments and high quality care.

- Develop new Medicare payment systems in FFS & Medicare+Choice.
- Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.

Promote understanding of CMS programs among beneficiaries, the health care community, and the public.

- Improve effectiveness of dissemination of Medicare information to beneficiaries
- Improve Medicare's administration of the beneficiary appeals process.
- Improve beneficiary understanding of basic features of the Medicare program.
- Increase awareness about the opportunity to enroll in the Medicare Savings Programs.

Promote the fiscal integrity of CMS programs and be an accountable steward of public funds.

- Maintain CMS's improved rating on financial statements.
- Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program.
- Reduce the Medicare contractor error rate.
- Improve the Medicare provider compliance rate.
- Improve the effectiveness of the administration of the Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data exchange agreements with insurers or employers.
- Increase referral of eligible delinquent debt for cross servicing.
- Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring & ultimately reducing Medicaid payment error rates.
- Assess program integrity customer service.
- Improve the provider enrollment process.
- Improve management of Survey & Certification budget development & execution process.

Foster excellence in the design and administration of CMS programs.

- Improved beneficiary telephone customer service.
- Improve CMS's oversight of Medicare fee-for-service contractors.
- Develop & implement information technology architecture.
- Improve CMS's information systems security.
- Increase the use of electronic commerce/standards in Medicare.
- Improve CMS's workforce planning.
- Improve CMS's management structure.
- Strengthen and maintain diversity at all levels of CMS.
- Implement CMS Restructuring Plan to create a more citizen-centered organization.

Provide leadership in the broader health care marketplace to improve health.

- Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.
- Assess the relationship between CMS research investments & program improvements.

***Please note:** A performance goal may be linked to more than one strategic goal. Primary linkages are represented here.

A.2.a Changes In Annual Performance Plan (APP) Goals

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Medicare Benefits						
Improve satisfaction of Medicare beneficiaries with the health care services they receive. (Beginning FY 2001: the goal includes data from disenrollees.)	● ✓	● ✓	● ✓	● ✓	✓	✓
Enroll beneficiaries into managed care plans timely. FY 2002-2003: Process Medicare+Choice Organization elections in compliance with the BBA beneficiary election provisions.	○ ✓	● ✓	● ✓	○ ✓		
Improve Medicare's administration of the beneficiary appeal process.		○ ✓	Ⓟ ✓	Ⓟ ✓	✓	✓
Increase health plan choices available to Medicare beneficiaries removed in FY 2001 to focus on areas under CMS's control.	○ ✓	● ✓				
Quality of Care: Quality Improvement Organizations						
Improve heart attack survival rates.		○ ✓	🕓 ✓	🕓 ✓		
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal. (Beginning FY 2001: lifetime pneumococcal vaccination included and data source changed from NHIS to Medicare Current Beneficiary Survey to include institutional based beneficiaries.)	● ✓	● ✓	Ⓟ ✓	🕓 ✓	✓	✓
Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram. (Beginning FY 2001: data source changed from NHIS to Medicare claims data to include institutional based beneficiaries.)	● ✓	● ✓	● ✓	🕓 ✓	✓	✓
Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.			● ✓	🕓 ✓	✓	✓
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection.					✓	✓
Quality of Care: Survey & Certification						
Decrease the prevalence of restraints in nursing homes.	● ✓	● ✓	● ✓	🕓 ✓	✓	✓
Decrease the prevalence of pressure ulcers in nursing homes.		● ✓	○ ✓	🕓 ✓	✓	✓
Improve the management of the Survey and Certification budget development and execution process.			● ✓	● ✓	✓	✓
Grants to States for Medicaid/Medicaid Agencies						
Work with States to develop Medicaid program performance goals. (Beginning FY 2000 increase the percentage of Medicaid two-year old children who are fully immunized.)	● ✓	● ✓	● ✓	● ✓	✓	✓
Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.	● ✓	● ✓	● ✓	● ✓		
Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.			○ ✓	● ✓	✓	✓
Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP).					✓	✓
Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance.	● ✓	● ✓	Ⓟ ✓			

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
State Children's Health Insurance Program						
Decrease the number of uninsured children by working with States to implement SCHIP and increase enrollment of eligible children in Medicaid.	● ✓	● ✓	● ✓	● ✓	✓	✓
Clinical Laboratory Improvement Amendments (CLIA)						
Improve laboratory testing accuracy. (Beginning FY 2000 sustain improved laboratory testing accuracy.)	● ✓	● ✓	● ✓	🕓 ✓	✓	
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.						✓
Medicare Integrity Program						
Reduce the percentage of improper payments made under the Medicare fee-for-service program.	● ✓	● ✓	○ ✓	○ ✓	✓	✓
Develop and implement methods for measuring program integrity outcomes.			● ✓	Ⓟ ✓	✓	
Improve the effectiveness of program integrity activities through the successful implementation of the Comprehensive Plan for Program Integrity. Goal was completed in FY 2001.			🕓 ✓			
Increase Medicare Secondary Payer liability & no-fault dollar recoveries. Focus changed beginning FY 2001 to increase Medicare Secondary Payer credit balance recoveries and/or decrease recovery time. FY 2003: Improve the process of credit balance recoveries.		● ✓	● ✓	● ✓	✓	
Assess program integrity customer service.				● ✓	✓	✓
Improve the provider enrollment process.				Ⓟ ✓	✓	✓
Improve the effectiveness of the administration of Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data exchange agreements with insurers or employers.						✓
Reduce the Medicare contractor error rate.						✓
Improve the Medicare provider compliance rate.						✓
Improve the efficiency of the medical review of claims. Goal discontinued, focus change from quantity to quality.		○ ✓				
Reduce the percentage of Medicare home health services provided for which improper payment is made.	● ✓	○ ✓				
Increase the ratio of recoveries identified to audit dollars spent. (Discontinued after FY 2000 due to data source concerns.)		● ✓				
Medicare Operations						
Improve beneficiary telephone customer service.		○ ✓	● ✓	Ⓟ ✓	✓	✓
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.		● ✓	● ✓	● ✓	✓	✓
Increase the use of electronic commerce/standards in Medicare.	● ✓	● ✓	Ⓟ ✓	● ✓	✓	✓
Maintain CMS's improved rating on financial statements.	● ✓	● ✓	● ✓	● ✓	✓	✓
Improve CMS oversight of Medicare fee-for-service contractors.			● ✓	● ✓	✓	✓

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Increase referral of eligible delinquent debt for cross servicing.				○ ✓	✓	✓
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service. (In FY 2000, combined with the National *Medicare & You* Education Program beneficiary information goal, below.)		● ✓	● ✓	● ✓		
Improve effectiveness of dissemination of Medicare information to beneficiaries (Beginning FY 2001: fee-for-service component split as a new goal under Medicare Operations)		● ✓	● ✓	● ✓	✓	✓
Improve beneficiary understanding of basic features of the Medicare program.			● ✓	● ✓	✓	✓
Ensure millennium compliance (readiness) of CMS computer systems.	● ✓	● ✓				
Federal Administrative Costs						
Develop and implement an information technology architecture.		● ✓	Ⓟ ✓	● ✓	✓	✓
Develop new Medicare payment systems in fee-for-service and Medicare+Choice.	● ✓	● ✓	● ✓	● ✓	✓	✓
Improve CMS's workforce planning.				● ✓	✓	✓
Improve CMS's management structure.					✓	✓
Strengthen and maintain diversity at all levels of CMS.					✓	✓
Increase awareness about the opportunity to enroll in the Medicare Savings Programs.				● ✓	✓	✓
Implement CMS Restructuring Plan to create a more citizen-centered organization.					✓	✓
Ensure compliance with HIPAA requirements through the use of policy form reviews.		● ✓	● ✓			
Research, Demonstration, and Evaluation						
Assess the relationship between CMS research investments and program improvements.	● ✓	Ⓟ ✓	● ✓	● ✓	✓	✓
Revitalization Plan						
Improve CMS's information systems security. (FY 2000 – FY 2003 in Federal Administrative Costs budget category)		○ ✓	Ⓟ ✓	🕓 ✓	✓	✓

✓ **Goal in identified year**
● **Goal met**
○ **Goal not met**
Ⓟ **Goal partially met**
🕓 **Final data pending**

A.2.b Revised Final FY 2003 GPRA Annual Performance Plan Goals

Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions MB3-03

Original FY 2003 Target
Medicare+Choice organization (M+CO) election transactions are accepted and used to update beneficiary data timely. Target percentage to be developed based on data collected in last quarter of FY 2002.

Revised Final FY 2003 Target
Due to legislation, this goal has been discontinued.

Rationale
Due to the passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002), the implementation of the lock-in provisions has been statutorily delayed until FY 2005. Because there will be no data to report in FY 2003 and FY 2004, this goal is discontinued.

Improve Medicare's Administration of the Beneficiary Appeals Process MB4-03

Original FY 2003 Target: Developmental.
M+CO: Begin collecting data to establish baseline.
FFS: A pilot program is under consideration to analyze FFS appeal data already collected from fiscal intermediaries and carriers.

Revised Final FY 2003 Target
Developmental.
M+CO: Enhance data collection at the Independent Review Entity (IRE) level.
FFS: Developmental.

Rationale
This data collection will eliminate any additional reporting burdens on the M+COs. The Benefits Improvement and Protection Act (BIPA) of 2000 mandated a new appeals process, which will change the requirements for FFS data collection.

Improve Heart Attack Survival Rates By Decreasing Mortality QIO1-03

Original FY 2003 Target
To decrease the 1-year mortality rate to 27.4 percent among Medicare beneficiaries following hospital admissions for heart attack.

Revised Final FY 2003 Target
This goal has been discontinued.

Rationale

There are a number of interventions that have proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. The CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal QIO2-03

Original FY 2003 Target (Pneumococcal)

To achieve a 69 percent lifetime pneumococcal vaccination rate among Medicare beneficiaries age 65 years and older.

Revised Final FY 2003 Target (Pneumococcal)

To achieve a **67** percent lifetime pneumococcal vaccination rate among Medicare beneficiaries age 65 years and older.

Rationale

Most recent MCBS data indicate that the rate for pneumococcal vaccinations is slowing down from what has been seen in recent years. In light of this information, we are revising our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older. The CMS will continue to actively promote the receipt of lifetime pneuomococcal vaccinations, and we will continue monitoring trends.

Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram QIO3-03

Original Baseline

45 percent of female FFS Medicare beneficiaries age 65 years and older received a mammogram within a two-year period (1997-1998 National Claims History File data).

Revised Baseline

51 percent of female FFS Medicare beneficiaries age 65 years and older received a mammogram within a two-year period (2000-2001 National Claims History File data).

Original FY 2003 Target
To increase to 53 percent Medicare beneficiaries age 65 years and older who will have received a mammogram in a two-year period (National Claims History File).

Revised Final FY 2003 Target
To increase to **51.5** percent Medicare beneficiaries age 65 years and older who will have received a mammogram in a two-year period (National Claims History File).

Rationale
The baseline and target have been revised to attain consistency with the 2002 HEDIS® measure and to reflect changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

Protect the Health of Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection QIO5-03

New FY 2003 Goal
The goal to protect the health of beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection is a component of the Surgical Site Infection Prevention (SIP) Project, which is currently being implemented by our QIOs. The focus of this goal is to decrease the complications from infection following a surgical procedure by increasing the rate by which antibiotics are administered in the recommended timeframe. By doing this we will be able to improve the health care outcomes for our beneficiaries, while decreasing the morbidity and mortality, and overall health care costs.

Rationale
This goal has been added to the performance plan in order to incorporate the new initiatives included in the Seventh Scope of Work as well as the initiative on preventive health.

Improve the Management of the Survey and Certification Budget Development and Execution Process QSC-03

Original FY 2003 Target
Allocate FY 2003 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care **and** non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.

Revised Final FY 2003 Target
Allocate FY 2003 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care **and/or** non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.

Rationale
We remain committed to analyzing average hours for both long term care and non-long term care surveys as part of the budget methodology. However, due to the uncertainty of the appropriations process and future resource challenges facing State survey agencies, CMS is unsure about the feasibility of this approach and its impact on State survey agencies. Therefore, and if necessary, we have decided to allow the flexibility to continue our current focus on long term care survey hours only.

Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates MMA4-03

Original FY 2003 Target
Expand the PAM Program to fifteen States. Pilot test the CMS PAM Model with ten of these States; pilot test innovative alternative payment accuracy methodologies with five States. Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to finalize specifications for the CMS PAM Model.

Revised Final FY 2003 Target
Expand the Medicaid PAM Project to **twelve** States. **Pilot test the CMS PAM Model in all twelve of these States.** Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to develop draft final specifications for the CMS PAM Model.

Rationale
The target for this goal has been changed to reflect the actual number of States that will participate in the Medicaid PAM Project during FY 2003. Twelve proposals were received from States in response to the all State solicitation sent to State Medicaid Directors, May 7, 2002; all twelve of the States that have applied to participate in the PAM Project during FY 2003 will be awarded PAM Project grants. As such, the program will expand from nine States in FY 2002 to twelve States during FY 2003. All twelve States will pilot test the CMS PAM Model. CMS will not pilot test alternative payment accuracy methodologies in FY 2003.

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) MMA5-03

Original FY 2003 Title
Improve Health Care Quality Across the Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project (PMPP)

Revised FY 2003 Title
Improve Health Care Quality Across the Medicaid and State Children's Health Insurance Program (SCHIP)

Rationale (for revised title)
CMS is revising the title of this goal to be more inclusive of the all of the Medicaid and SCHIP activities to improve health care quality.

Original FY 2003 Target
To begin working with States on the Performance Measurement Partnership Project (PMPP).

-- **Medicaid**

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; and **(b)** Initiate action steps for implementing recommendations.

-- **SCHIP**

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b)** Initiate action steps for implementing recommendations; and **(c)** Begin to implement core SCHIP performance measures.

Revised FY 2003 Target
To begin working with States on the Performance Measurement Partnership Project (PMPP).

-- **Medicaid**

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement**; and **(c)** Initiate action steps for implementing recommendations.

-- **SCHIP**

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; **(b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement**; **(c)** Initiate action steps for implementing recommendations; and **(d)** Begin to implement core SCHIP performance measures.

Rationale (for revised target)
We are adding this milestone to our target to include all of the major steps that CMS and the States are taking toward reaching a measurable goal.

Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid SCHIP1-03

Original FY 2003 Target
To be determined. Currently, we are in the process of re-evaluating the goal and anticipate releasing a revised goal in early FY 2002.

Revised Final FY 2003 Target
Increase the number of children who are enrolled in regular Medicaid or SCHIP by five percent over the previous year.

Rationale
When The State Children's Health Insurance Program began in 1997, CMS implemented an enrollment goal to enroll five million children in the program by FY 2005. Because we have exceeded this goal and are now seeing States face fiscal challenges that may affect program outreach and enrollment, we are less sure about future projections and have decided to set our FYs 2003 and 2004 targets to increase enrollment by five percent over the previous year.

Improve the Process of Credit Balance Recoveries MIP5-03

Original FY 2003 Goal Title
Increase Medicare Secondary Payer (MSP) Credit Balance Recoveries and/or Decrease Recovery Time to Recoup Dollar Recoveries

Revised FY 2003 Goal Title
Improve the Process of Credit Balance Recoveries

Rationale
The title for this goal has been revised to more accurately reflect the activity.

Improve Beneficiary Telephone Customer Service MO1-03

Original Baseline
Developmental. Baseline data on accessibility, accuracy of response, and caller satisfaction are being collected and will be available by the end of FY 2002.

Revised Final Baseline
National quality targets defined. Currently no standardization of telephone call centers; one pilot underway.

Original FY 2003 Target
Using baseline data, establish call center performance targets for accessibility, accuracy of response, and caller satisfaction. Collect monthly data from each call center and compare performance against targets, identify where improvements are needed on national and regional levels. Take necessary actions and/or conduct training to bring about improved performance. Specific target goals to be determined.

Revised Final FY 2003 Target
(1) Quality Standards:
- Minimum of 85 percent pass rate for Adherence to Privacy Act
- Minimum of 90 percent meets expectations for Customer Skills Assessment
- Minimum of 85 percent meets expectations for Knowledge Skills Assessment

(2) Begin national expansion of 1-800-MEDICARE

Rationale
A shift in Agency priorities and the strategy for telephone customer service required a redirection of funding for the national caller satisfaction survey to a pilot operation in Pennsylvania (beneficiaries calling a single 800 number) in early FY 2002. The CMS also made the development and implementation of a standard desktop for customer service representatives at contractor call centers one of its highest priorities for telephone delivery. This shift towards the national expansion of 1-800-MEDICARE as the single beneficiary inquiry line reflects a significant systems change that will improve responsiveness to our beneficiaries. Given the lack of baseline data and the change in Agency priorities, the caller satisfaction and accessibility measures have been discontinued at this time.

Improve CMS Oversight of Medicare Fee-for-Service Contractors MO5-03

Original FY 2003 Target
Developmental.

Revised Final FY 2003 Target
Building on program achievement in prior years, CMS will move further toward its goal of national uniform contractor evaluation.

Rationale
This is a developmental goal following a timeline to reach a national uniform contractor evaluation.

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries through the National *Medicare & You* Education Program (NMEP) MO8-03

Original FY 2003 Title
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries through the National *Medicare & You* Education Program (NMEP)

Revised Final FY 2003 Title
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries

Rationale
The reference to NMEP was removed from the title so as not to limit the focus of this goal. While NMEP efforts will have an impact on beneficiary behavior affecting the outcome of this goal, the NMEP alone does not control whether or not we meet our targets. In addition, there are other pertinent activities outside of NMEP which can contribute to the outcome of this goal.

Improve Beneficiary Understanding of Basic Features of the Medicare Program MO9-03

Original Baseline
Developmental.

Revised Final Baseline
(1) Beneficiaries were able to answer correctly 2.75 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
(2) Fifty-three percent of Medicare beneficiaries were aware that Medicare has a 1-800 information number.

Original FY 2003 Target
Developmental.

Revised Final FY 2003 Target
Continue collecting and monitoring the Medicare Current Beneficiary Survey (MCBS) data on (1) & (2) above for reporting on FY 2004 targets.

Rationale
The FY 2002 goal was to develop baselines/targets to:
- improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively, and
- improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

The baselines and targets are shown above.

Develop and Implement an Information Technology Architecture FAC2-03

Original FY 2003 Target
Continue maturing the ITA, including further expansion of both breadth and depth, as opportunities and needs arise. Develop architectural support services for enterprise-wide use, for example, business modeling or technology assessment. Implement IT policies and procedures, and continue additional IT policy and procedure development for needed subject areas.

Revised Final FY 2003 Target
Continue to develop the ITA (Enterprise Architecture), including further expansion of both breadth and depth using a segmented approach, with specific segments determined as opportunities and needs arise. Complete development and promulgation of remaining IT policies.

Rationale
Goal is moving forward and implementation of policy and procedures has and will continue to occur.

Increase CMS's Information Systems Security FAC3-03*

Original FY 2003 Target
Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Implement improved access control management system. Conduct penetration testing and vulnerability assessments at a subset of Medicare contractors and CMS service providers. Include systems security reviews in Contractor Performance Evaluations (CPEs).

Revised Final FY 2003 Target
Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Implement improved access control management system.

Rationale
The major emphasis of this goal is to close the security gaps at the contractor level. All available resources are being used to fund implementation of the security safeguards necessary to comply with CMS's baseline security requirements.

***See new FY 2004 Revitalization Plan budget category for more information.**

Improve CMS's Workforce Planning FAC6-03

Original Baseline
Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2003.

Revised Final Baseline
Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2004.

Original FY 2003 Target
Fully implement automated workforce planning system, including updating previously collected data and establishing a knowledge and skill level baseline.

Revised FY 2003 Target
Complete development of and implement automated workforce planning modules.

Rationale
During FY 2002, a prototype system was developed. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. Completion of these modules is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

Improve CMS's Management Structure FAC7-03

Original FY 2003 Target
(a) Performance Management: Full implementation of a competency-based performance management system for non-Senior Executive Service (non-SES) managers; **(b)** Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and **(c)** Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Revised FY 2003 Target
(a) Performance Management: Full implementation of a competency-based performance management **(planning and appraisal) program** for non-Senior Executive Service (non-SES) managers; **(b)** Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and **(c)** Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Rationale
We are revising the target language to clarify that the Performance Management System is a planning and appraisal program for non-SES managers.

Increase Awareness of the Opportunity to Enroll in the Medicare Savings Programs FAC9-03

Original FY 2003 Target
To be determined. We will increase awareness of Medicare Savings Programs and set target based on FY 2002 baseline.

Revised FY 2003 Target
Increase awareness of Medicare Savings Programs to 13 percent.

Rationale
We are revising the target language because the FY 2002 baseline has been established and future targets have been developed.

Assess the Relationship between CMS Research Investments and Program Improvements R1-03

Original FY 2003 Target
Repeat internal and external assessments.

Revised FY 2003 Target
Conduct internal assessment.

Rationale
Based on the recommendations made by the external reviewers and CMS research leadership, we plan to continue annual internal assessments and to further integrate them with our work planning and budgeting processes. However, since research agendas and findings are usually part of an ongoing multiyear process, we believe it will be more effective to perform external reviews every 3 years. We will conduct our next external assessment in FY 2005.

A.3 Partnerships and Coordination

The CMS accomplishes its mission by working closely with many other organizations. This includes working relationships with CMS agents (Medicare contractors, State Medicaid Agency staff, State surveyors, and Quality Improvement Organizations, providers of care (hospitals, physicians, health plans, clinical laboratories, etc.), beneficiary and consumer organizations, accrediting bodies (the Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance), and researchers who work together to ensure high quality care for nearly 82 million Medicare and Medicaid beneficiaries.

The CMS continues to increase coordination with States in the performance plan process. State Medicaid agencies are directly involved in carrying out the goals for decreasing the number of uninsured children; assisting States in conducting Medicaid

payment accuracy studies, linking Medicare and Medicaid data; and increasing rates of immunization for Medicaid children.

The CMS works closely with a number of other Federal agencies, both within and outside HHS, on special programs and crosscutting issues. For example:

- The CMS depends on assistance from the Centers for Disease Control and Prevention (CDC) in our efforts to increase influenza and pneumococcal vaccination rates.

- The CMS, the HHS Inspector General, the FBI, and the Administration on Aging work together to reduce fraud, waste, and abuse.

- The CMS, the Health Resources and Services Administration (HRSA), and other HHS agencies (e.g., CDC and Agency for Healthcare Research and Quality) are working together to improve children's access to health care services.

- The CMS and the CDC are providing ongoing technical assistance to States as they explore methodologies and develop baselines for measuring the number of Medicaid two-year olds who are fully immunized.

Working in partnership leverages resources and increases coordination, which is ultimately in the beneficiaries' best interest. Each performance goal narrative includes a coordination section.

A.4 Data Issues – Data Verification and Validation

The CMS uses many data systems to measure its performance on GPRA goals. Each goal in the APP contains a section on data verification and validation and describes any limitations of the data sources. Relying on a number of administrative and survey data systems presents certain difficulties and vulnerabilities. For example, there are inherent time lags between the actual data submission, data compilation, and the due dates for report submissions. Goals for which data are not yet available will be included in a subsequent Annual Performance Report.

The CMS conducts comparisons across similar data systems where practical to ensure validity and reliability of data sources. For example, under performance goal MB1-04 (a goal to improve Medicare beneficiary satisfaction with services), the Medicare Consumer Assessment of Health Plans Study (CAHPS) is used to assess beneficiary satisfaction with health plans. We will check the consistency of CAHPS data with similar data from the Medicare Current Beneficiary Survey. Another approach we employ to ensure data quality is the use of consistency edits. For example, the On-line Survey and Certification and Reporting (OSCAR) data system (used to measure the prevalence of restraints in nursing homes) measures State-to-State and facility-to-facility variation within data elements. Our experience has shown that these variations have been relatively constant, resulting in national measurements with high reliability.

In addition to data already available through CMS systems, CMS's APP relies on survey data, evaluations, and special studies conducted by other Federal agencies. The CMS relies on these agencies to verify and validate their data. External data sources enable us to conserve resources by minimizing duplication of effort. Since most of these surveys, studies, and audits are conducted for multiple purposes, refinements of methods and definitions that strengthen data collection for one purpose may weaken the usefulness of the information of CMS's performance measurement under GPRA. If a data source changes in a manner that diminishes its appropriateness for our performance measure or a better data source is identified, we will evaluate our approach. For instance, in our mammography goal, we are now using Medicare claims data since the National Health Interview Survey did not include institutional-based beneficiaries.

One of the biggest challenges that we face in the analysis of performance data is timeliness. In some cases, there are inherent time lags between the actual data submission, data compilation, and the due dates for report submission.

A.5 Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning, and Program Evaluation

Linking Performance Measurement to the CMS Budget

We have taken care to ensure that major budget categories, including both program benefits and program administration funds, have adequate coverage in the APP. Our performance plan and report are organized by budget category to provide a linkage of performance goals, program activities and dollar amounts. These linkages ensure that in setting performance goals, CMS selects goals that are representative of the full range of Agency activities and resources.

Linking Performance Measurement to Cost Accounting

We select the performance goals in CMS's APP based on the fact that, collectively, they broadly represent the work of the Agency. Where appropriate, explicit cost linkages exist. In other cases explicit cost linkages are not made, but activities are linked to budget categories as explained above. The CFO clean opinion goal shows our commitment to clear and complete accounting for funds across the Agency.

Linking Performance Measurement to Information Technology (IT) and Capital Planning

Capital investment, primarily in the form of technology, supports all of CMS's goals. The CMS technology investments are funded through the Agency's annual Information Technology (IT) budget, which in turn is funded from several of CMS's accounts.

We have continued to include information technology planning in the FY 2004 APP in our goal to develop and implement an information technology architecture, as required by the Clinger-Cohen Act of 1996 and in alignment with CMS's strategic business

objectives. We believe implementation of the full process must be phased to be fully successful, and our performance goal reflects that approach.

Performance Measurement Linkages with Program Evaluation

The CMS performs, coordinates, and supports research and demonstration projects (through studies, contracts, grants, and waivers) to develop and implement new health care financing policies and to evaluate the impact of CMS's programs on beneficiaries, providers, States, Tribes, and other customers and partners. The scope of CMS's research, demonstration, and evaluation activities embrace all areas of health care relevant to CMS programs: costs, access, quality, service delivery models, and financing approaches.

The CMS has planned several program and demonstration evaluations over the next five years and beyond to assess our strategies for improving our programs. Findings from our demonstration evaluations will be used to help CMS plan for the future of our programs and modify strategies for accomplishing our APP and strategic goals. We have included in our APPs a performance goal, which directly assesses our research and demonstration activities.

We consider the evaluation work of others, such as the Office of Inspector General, the General Accounting Office, and the Medicare Payment Advisory Commission, in developing our performance plan. Findings from evaluation by these entities have influenced our choice of performance measures, including the Medicare fee-for-service error rate goal and our goal to stratify the Medicare payment error rate to strengthen our ability to target problem areas.

The CMS strongly emphasizes its priorities in its performance plans. Going into our fourth year of reporting, the process is already having an effect on the management of our programs as indicated in the reports. Reporting over time will reveal trends, which will increase the usefulness of the GPRA process in the management of CMS's programs.

A.6 Developmental Goals Timeline

Some of our goals are labeled "developmental" goals. We include these goals in our plan to show our commitment to certain priorities while acknowledging the challenges of developing a specific, measurable goal.

Improve Medicare's Administration of the Beneficiary Appeal Process (MB4-04)

FY 2000
- Implement system for collecting appeals data from Medicare+Choice Organizations (M+CO) (was indefinitely delayed due to additional burden).

FY 2001
- OPL published April 27, 2001.

FY 2002
- Issued OPL with reporting instructions for M+COs.
- Evaluated CMS's FFS appeal data needs and capabilities.

FY 2003
- Enhance data collection at the Independent Review Entity (IRE) level for M+COs.

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (MMA5-04)

FY 2003
- The CMS and States will identify a strategy for improving health care delivery and/or quality and specify the measures for gauging improvement.
- Develop timeline for implementing the strategy identified by CMS and States.
- Develop data submission, methodological, and reporting processes.
- 2002 data will be collected from States (testing phase).

FY 2004
- Data submission, methodological processes, and reporting will be refined.
- Produce 2002 performance measures in standardized reporting format (testing phase).
- 2003 data (baseline) will be collected from States.

FY 2005
- Reporting of 2002 and 2003 performance measures in standardized reporting format.
- 2004 data will be collected from States.
- Implementation of the targeted quality improvement programs will commence.

FY 2006
- Reporting of 2002 (testing), 2003 (baseline) and 2004 performance measures in standardized reporting format
- Re-measurement will occur with 2005 data.
- New quality improvement cycle begins.

FY 2007
Evaluation and Final Report.

Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver (CLIA2-04)

FY 2003
- Developing educational materials and resources for laboratories.
- Continue to conduct surveys of laboratories holding a certificate of waiver on a nationwide scale.
- Collecting baseline data on which to measure improvement and setting future targets.

FY 2004
- Continue to conduct surveys of laboratories holding a certificate of waiver on a nationwide scale, including referral of laboratories to the educational materials and resources developed in FY 2003.
- Re-assess the need for continuation of this project into FY 2005 and beyond.
- Assess the other opportunities available to further ensure that laboratories performing waived tests can improve and sustain testing accuracy.

Improve CMS Oversight of Medicare Fee-For-Service Contractors (MO5-04)

FY 2001
- Evaluated and further refined the risk analysis methodology.
- Evaluated, further improved and continued to develop national review protocols.
- Developed a comprehensive set of clear and measurable contractor performance standards.
- Completed development of and implemented a national CPE database to provide management information on the progress of CPE 2001.
- Performing pre-issuance quality assessment of review reports to ensure greater consistency.
- Started reviews in the first quarter of FY 2001.
- Conducted a national Lessons Learned Conference for over 150 reviewers.
- Performed pre-issuance quality assessment of review reports to ensure greater consistency.
- Completed and issued rewrite of CPE portion of the Regional Office Manual.
- Issued eleven CPExtras providing real time CPE operational policy guidance.
- Implemented a contractor rebuttal process.

- Began development of a training curriculum for CPE reviewers.
- Provided feedback on performance by business function to Central Office program managers.
- Issued 37 annual FY 2000 Reports of Contractor Performance to the CEO's of each corporation serving as a Medicare contractor.

FY 2002

- Again used FY 2001 CPE Risk Assessment Matrix to ensure any contractor not previously selected in our 3-year cyclical approach for on-site CPE business function reviews is evaluated by the end of FY 2003.
- Evaluated national review protocols with the goal of further improvement and consistency in format and terminology.
- Developed plan and timeline for issuance to contractor executives of FY 2002 Reports of Contractor Performance.
- Made further enhancements to the CPE national database in the fourth quarter of FY 2002.
- Identified issues to raise and clarifications to make during FY 2003 Lessons Learned Conference by conducting reviews of FY 2002 work papers on a limited number of reviews.
- Submitted for Clearance to the Department the Federal Register notice of Criteria and Standards for Evaluating the Contractors in FY 2003.

FY 2003

- Planning further improvements to national review protocols.
- Are again selecting regional office managers to serve as Project Leaders for teams evaluating a specific business function.
- Will conduct national Lessons Learned Conferences.
- Will conduct training of all CPE reviewers on each of the protocols, videotape the training and provided copies to each of the regional offices.
- Continue to enhance the CPE national database as needed.
- Planning to keep a core of RO-CO review team members together (where feasible) on all reviews they conduct.
- Planning to continue to conduct pre-issuance quality assessment of review reports to ensure greater consistency.
- CPE requires close coordination with other CMS components that are responsible for the various business functions handled by fee-for-service contractors. The Office of Financial Management (OFM) has responsibility for the payment safeguard and financial business functions. OFM plans to contract in FY 2003 with independent audit firms to conduct SAS-70 reviews of contractors in the various business functions for which it has responsibility. These SAS-70s are to be used in place of conducting CPE evaluations. We will coordinate with OFM and determine a means to incorporate those findings into the overall performance picture we supply to contractor executives sometime after the close of the fiscal year.
- There will be fewer CPE reviews conducted in FY 2003 by CMS reviewers compared to FY 2002. Most CMS reviews will be in business functions such as

customer service, appeals, claims processing, provider enrollment and reimbursement. Reviews of other functions will be conducted by SAS-70s

Improve CMS's Workforce Planning (FAC6-04)

FY 2000

- The CMS developed a competency catalogue of skills and knowledge required to accomplish Agency functions.

FY 2001

- Using this catalogue, CMS inventoried current employee competencies.
- We intended to determine baselines and targets for FY 2002 using the inventory data. However, the inventory was too cumbersome to ask staff to complete in the same format in the future. Instead, CMS:
  - Identified several specific gaps critical to meeting strategic goals.
  - Began actions to increase skills in these areas – via recruitment, development, and/or redeployment.
  - Initiated design of a dynamic, Intranet-based system to house workforce planning data.

FY 2002

- The CMS built an initial prototype for an Intranet-based system to house and track workforce planning data. Based on the prototype, CMS decided to build a series of Agency-specific workforce planning modules linked to the CMS Human Resource Information System, rather than a "stand-alone" workforce planning system.
- The CMS monitored and evaluated actions taken to increase targeted skill areas.
- The CMS determined future knowledge and skill requirements.
- The CMS defined work roles and assigned each position in the agency to a primary work role.

FY 2003

- The CMS will test the logic for a series of automated workforce planning modules.
- The CMS will build, test, and populate automated workforce planning system modules.
- The CMS will continue to monitor and evaluate actions taken to increase targeted skill areas.

FY 2004

- The CMS will fully implement a series of automated workforce planning modules, including updating data collected in FY 2000 through 2002.
- The CMS will determine baselines and targets for FY 2005.

Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization (FAC10-04)

FY 2003

- Pending additional Administration guidance, further restructuring activities for FY 2004 will be targeted.

Appendix B

State Methodologies and Reporting for the GPRA Medicaid Childhood Immunization Goal (MMA2-03)

Due to the various data collection and reporting methodologies used by individual States, immunization coverage levels are not directly comparable across States. Each State will measure its own progress, using a consistent measurement methodology.

The following Appendix summarizes State-specific methodologies and includes relevant definitions and presents each State's baseline and three-year targets for increasing childhood immunization rates.

Group I States

Although all Group I States have actively participated, there have been problems and barriers that have delayed reporting. Fifteen of the 16 Group I States have reported their first re-measurement rate. California is the only outstanding state. California lost funding for the chart review method of collecting the data used for the baseline measure and must rely on HEDIS® and National Immunization Survey (NIS) data for its reporting. This report will be forthcoming as soon as NIS results for 2002 are released from CDC at which time California intends to report its first re-measurement.

Twelve of 16 States have reported their second re-measurement rate. Idaho experienced delays early in the project as a result of their governor's initiative. Kansas is delayed due to problems in data collection and staff turnover early in the project.

Group II States

Group II States actively participated in the project, but also experienced delays. All Group II States submitted their state-specific methodologies, baseline and three-year target rates.

Five of 10 Group II States have reported their first re-measurement rate. Delaware, District of Columbia and Florida are expected to report by the end of 2002. Alaska has had trouble getting the information by their timeline due to government reorganization and moving of offices to another city. New Hampshire has had some frustration in obtaining the data according to the methodology and has hired new contractors to move this project back on schedule.

Group III States

The third and final group of this project have prepared their baseline methodologies, but have also experienced delays with several States requesting extensions. Seventeen of

the 24 Group III States have reported their baselines and most of those 16 have also established targets. Georgia asked for an extension due to difficulty verifying the data. Illinois had some data issues to resolve and plans to report in early 2003. Indiana has had numerous staff turnover and has asked for an extension to determine the rate. New Mexico needed to change their methodology and requested an extension of the report deadline. Pennsylvania, New York, and Vermont ran into some problems obtaining a final rate for their baselines. Texas determined the NIS to be the source of their rate and must wait for CDC to release the rates. All States indicated they plan to be up to date in 2003.

Appendix B

Baseline Measurement Methodologies for the GPRA Medicaid Childhood Immunization Goal

Group I States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Arizona	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(a, b, c)	FY 1999	75%	78%	78%	2003	80%
Arkansas	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(b, c)	7/1/97 – 6/30/98	65%	74%	67%	2003	90%
California	MCP & FFS 2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4 (c)	CY 1998	54%	Pending	Pending	2003	65%
Connecticut	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(a)	CY 1998	77%	75%	76%	2003	80%
Idaho	2-year old 1(b) Medicaid enrollment 2(b) Fully immunized 3(a)	4(c, d)	1/1/01 sample selection date	66%	65%	Pending	2003	76%
Iowa	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(h)	4(b, c)	CY 1998	58%	68%	68%	2003	90%
Kansas	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(c)	FY 2000	42%	50%	Pending	2003	90%
Maine	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(i)	4(c, a)	7/1/98 – 6/30/99	24%	32%	2002	2003	70%
Massachusetts	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(j)	4(b)	CY 1997	64%	69%	69%	2003	80%

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Michigan	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(k)	4(b)	CY 1997	49%	57%	65%	2003	90%
Mississippi	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(a)	4(a, d)	7/97 – 6/98	85%	85%	88%	2003	85%
Oklahoma	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(d)	4(a, b, d)	CY 1998	65%	76%	68%	2003	90%
Oregon	2-year old 1(a) Medicaid enrollment 2(e) Fully immunized 3(a)	4(a, b)	CY 1998	63%	67%	70%	8/03	67%
Rhode Island	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(k)	4(a, c, d)	CY 1998	75%	72%	67%	2003	79%
Utah	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(f)	4(a, b, c)	FY 1999	19%	27%	31%	2003	65%
Washington	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4(b)	CY 1998	58%	77%	80%	2003	58%

Group II States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Alaska	2-year old 1(b) Medicaid enrollment 2(p) Fully immunized 3(f)	4(c, e, d)	7/1/99 – 6/30/00	85%	Pending	2003	2004	88%
Colorado	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(i)	4(c)	CY 2000	48%	44%	2003	2004	52%
Delaware	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(a, c)	CY 1998	43%	2002	2003	2004	60%
District of Columbia	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(l)	4(a, c)	CY 1998	50%	2002	2003	2004	72%
Florida	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(a)	4(d)	01/98	82%	2002	2003	2004	90%
Louisiana	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(b)	CY 1998	82%	82%	2003	2004	84%
New Hampshire	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(j)	4(b, c, d)	CY 2000	67%	Pending	2003	2004	90%
North Carolina	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(e)	4(c)	CY 2000	34%	42%	2003	2004	60%
North Dakota	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(j)	4(a, c)	CY 2000	43%	45%	2003	2004	90%
South Dakota	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(a)	9/30/01	52%	62%	2003	2004	90%

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third re-measure	Target Rate
Alabama	**2-yr Old** 1(a) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(l)	4(a)	7/1/01 - 6/30/02	75%	2003	2004	2005	80%
Georgia	**2-yr Old** 1(b) **Medicaid Enrollment** 2(d) **Fully Immunized** 3(l)	4(d)	2/01 - 2/02	Pending	2003	2004	2005	pending
Hawaii	**2-yr. Old** 1(a) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(g)	4(c)	7/1/01 - 6/30/02	74%	2003	2004	2005	pending
Illinois	**2-yr. Old** 1(b) **Medicaid Enrollment** 2(a) (b) (c) **Fully Immunized** 3(l)	4(a, c)	Jan. 02	Pending	2003	2004	2005	pending
Indiana	**2-yr. Old** 1(a) & 1(b) **Medicaid Enrollment** 2(d) **Fully Immunized** 3(g) & 3(f)	4(b, c)	CY 2000	8%	2003	2004	2005	57%
Maryland	**2-yr. Old** 1(b) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(g)	4(a, b, c)	CY 2001	52%	2003	2004	2005	56%
Minnesota	**2-yr. Old** 1(a) **Medicaid Enrollment** 2(f) **Fully Immunized** 3(e)	4(c)	CY 2000	11%	2003	2004	2005	20%
Missouri	**2-yr. Old** 1(a) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(f)	4(c)	CY 2001	47%	2003	2004	2005	53%
Montana	**2-yr. Old** 1(b) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(f)	4(a, b, c, d)	CY 2001	81%	2003	2004	2005	pending
Nebraska	**2-yr. Old** 1(a) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(f)	4(a, c)	CY2001	44%	2003	2004	2005	70%

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Nevada	**2 yr. Old** 1(b) **Medicaid Enrollment** 2(c) **Fully Immunized** 3(a)	4(c, a)	FY 2001	66%	2003	2004	2005	80%
New Jersey	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(c) **Fully Immunized** 3(f), (g)	4(c)	CY 1999	44%	45%	2004	2005	60%
New Mexico	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(a) **Fully Immunized** 3(l)	4(c)	CY 2001	pending	2003	2004	2005	pending
New York	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(f), (a) **Fully Immunized** 3(c)	FFS - 4(c, b) MCO - 4(b, c)	Born Oct 1, 1998 - Dec 31, 1998	pending	2003	2004	2005	pending
Ohio	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(c) **Fully Immunized** 3(g)	4 (a, c, b, d)	SFY 2001	49%	2003	2004	2005	pending
Pennsylvania	**2 yr. Old** 1(e) **Medicaid Enrollment -**2(c) **Fully Immunized** 3(h)	4(a, c)	7/1/98 - 6/30/99	pending	2003	2004	2005	pending
South Carolina	**2 yr. Old** 1(k) **Medicaid Enrollment** 2 (o) **Fully Immunized** 3 (l)	4 (a, b, c, d)	CY2000	84%	2003	2004	2005	pending
Tennessee	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(d) **Fully Immunized** 3(a & g)	4(a, b, d)	Jan 1, 2002	60%	2003	2004	2005	80%
Texas	**2 yr. Old** 1(b) **Medicaid Enrollment** 2(b) **Fully Immunized** 3(a)	4(c)	7/01 – 6/02	pending	2003	2004	2005	pending
Vermont	**2 yr. Old** 1(b) **Medicaid Enrollment** 2(b) **Fully Immunized** 3(m)	4(b, c)	6/02	pending	2003	2004	2005	pending

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Virginia	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(c) **Fully Immunized** 3(a)	4(b)	7/99 – 6/00	69%	2003	2004	2005	85%
West Virginia	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(d) **Fully Immunized** 3(g), (l)	4(a, c)	CY2000	75%	2003	2004	2005	80%
Wisconsin	**2 yr. Old** 1(a) **Medicaid Enrollment** 2(f) **Fully Immunized** 3(f)	4(a, b, c, d)	CY2001	41%	2003	2004	2005	pending
Wyoming	**2 yr. Old** 1(b) **Medicaid Enrollment** 2(c) **Fully Immunized** 3(a)	4(b)	6/15/00	55%	38%	2004	2005	pending

APPENDIX B

Definition of two-year old:

1(a) States choosing to measure number of two-year olds over a period of time (i.e. using State or Federal fiscal year, calendar year, or a point in time such as January 1).

1(b) States measuring by age (i.e. 24 - 35 months of age, between 19 and 35 months of age or 0 to 24 months of age).

Medicaid enrollment:

2(a) Twelve months enrollment and have no more than 30 - 45 days gap in enrollment.

2(b) Enrolled for at sample date selected.

2(c) Enrolled at least 6 months

2(d) Ever enrolled.

2(e) Enrolled in Medicaid managed care

2(f) Enrolled at least 10 months with no more than 45 day gap in enrollment

Fully immunized:

3(a) 4 DTP, 3 OPV, 1 MMR

3(b) 4 DTP, 3 OPV, 1 MMR, 1 Hib

3(c) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 3 HBV; HEDIS (2001 & 2000, Comb 1; 1999, Comb 2)

3(d) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 2 HBV; HEDIS (1999, Comb 1; 1998, Comb 2)

3(e) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 3 HBV, 1 VZV; HEDIS (2001 & 2000, Comb 2; 1999, Comb 3)

3(f) 4 DTP, 3 OPV, 1 MMR, 3 Hib, 3 HBV; HEDIS (2002, Comb 1)

3(g) 4 DTP, 3 OPV, 1 MMR, 3 Hib, 3 HBV, 1 VZV; HEDIS (2002 & 1, Comb 2)

3(h) 4 DTP, 3 OPV, 1 MMR, 4 Hib, 3 HBV, 1 VZV (ACIP schedule 1998)

3(i) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 2 HBV; HEDIS (1998, Comb 1)

3(j) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 3 HBV

3(k) 4 DTP, 3 OPV, 1 MMR, 4 Hib, 3 HBV (ACIP/AAP recommendations)

3(l) 4 DTP, 3 OPV, 1 MMR, 3 Hib (NIS)

3(m) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 3 HBV, 1 VZV

3(n) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 2 HBV, 1 VZV; HEDIS (1998, Comb 3)

Data Sources:

4(a) Immunization registry

4(b) Chart review

4(c) Administrative data

4(d) Survey

4(e) Alaska Permanent Fund

GLOSSARY OF TERMS

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
CASA	Clinic Assessment and Software Application
CY	Calendar year
DTP/DTaP	Diptheria, Tetanus, Pertussis/ Diptheria, Tetanus, acellular Pertussis
EQR	External Quality Review
FFS	Fee-For-Service
GPRA	Government Performance and Results Act
HBV	Hepatitis B Vaccine
HEDIS	Health Plan Employer Data Information Set
HEDIS Hybrid	Hybrid - Using the above set along with other available data systems
Hib	Haemophilus Influenza type b
MCO	Managed Care Organization
MCP	Managed Care Program

APPENDIX B

MIS/DSS	Management Information System
MMR	Measles, Mumps, Rubella
OPV/IPV	Oral Polio Vaccine/Intramuscular Polio Vaccine
PCCMP	Primary Care Case Management Program